Advanced Practice in Nursing
Under the Auspices of the *International Council of Nurses (ICN)*
Series Editor: Christophe Debout

Susan B. Hassmiller
Joyce Pulcini *Editors*

Advanced Practice Nursing Leadership: A Global Perspective

Springer

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This series of concise monographs, endorsed by the International Council of Nurses, explores various aspects of advanced practice nursing at the international level.

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Introduction

> Meaningful innovation does not need to be based on outright invention. Rather, there is an exhilarating shortcut. It is based on bold, new combinations of already existing components that simultaneously unlock heightened levels of consumer value and reduce costs.—Gabor George Burt

(https://www.cio.com/article/3203028/13-disruption-quotes-to-kickstart-your-innovation.html)

In 2000, Christensen, Bohmer, and Kenagy used nurse practitioners as an example of a disruptive innovation in health care as they met a need for more primary health care providers. When specialty physicians increased, there was a shortage of physicians willing to provide this care and more tools became available for patients to engage in self-care. But as we look more closely, we see that throughout history many nurses have been disruptive innovators leading to change going back from Florence Nightingale herself to leaders like Loretta Ford, the founder of the Nurse Practitioner movement in the United States and Barbara Stilwell, the nurse who initiated the role in the United Kingdom and is a contributor to this book. Each of these leaders innovated by enhancing the role of nursing to heighten consumer value, reduce costs, and improve outcomes.

Advanced Practice Nurses (APNs) began in the United States and Canada more than 50 years ago but now are expanding globally all over the world. Now many other countries and regions around the world are striving to implement this role. The momentum is striking as we approach the year of the Nurse and Midwife in 2020.

This book provides an important contribution to the literature since it is one of the first books to focus on APN global leadership. As APNs rise globally and become more prevalent in countries all over the world, leadership concepts that promote and advance this role are needed. Each chapter outlines characteristics that define leadership for Advanced Practice Nursing. Numerous country-level examples are provided as well as examples from the leading global nursing organizations and international nursing leaders.

The book encompasses leadership through advocacy, entrepreneurship, coaching, and mentorship. Academic and clinical leadership are highlighted as well as leadership in business, non-governmental organizations, and other settings around the world. Characteristics that define leadership for APNs are highlighted, which go beyond traditional hierarchical managerial leadership to inspirational local and

horizontal leadership and pave the way for new health care models. Global APN leaders are often entrepreneurial and risk taking in their approaches and are ahead of the curve in creating high level and quality interventions at the community and country level. A key part of this leadership is succession planning, mentoring, and guiding the next generation of nurse leaders. This book tells the stories of leaders from across the globe and highlights new ideas that foster innovation.

In keeping with our focus on mentorship of new leaders, each chapter has a junior author highlighting the importance of succession planning to pave the way for the future. This focus is a key aspect of this book and will help to foster new leaders for the future.

The book begins with an introduction to leadership in the context of **21st Century APN Leadership** globally. It then discusses **Global Perspectives on APN Leadership** by calling on leaders from global nursing organizations such as the International Council of Nurses, Sigma Theta Tau International, Nursing NOW campaign, and the Future of Nursing: Campaign for Action from the U.S. Next **Case Studies in APN Leadership at the Regional or Country Level** are used with real-life examples and case studies of how leadership exerts itself in different countries and regions. The section on **Academic APN Leadership** focuses on maintaining and creating standards for education and on the importance of quality and health policy to guide leaders in academia. An example in Africa by SEED Global Health is presented highlighting how to improve education in the region. The section on **Clinical Leadership** discusses what it takes to be a leader in clinical and community settings, working on interprofessional teams to produce excellent outcomes. This section discusses creating strong clinical networks using an example from France, and another chapter addresses promotion of clinician well-being to create joy in work. Finally, the section on **Leadership Development** brings in concepts of mentoring and coaching, advocacy and entrepreneurship as integral to the role of a leader as they build a legacy. An example from Chile on collaborative leadership discusses how diverse stakeholders must be vetted in order to make lasting change. A chapter on Partners in Health, a global non-governmental organization, discusses leadership development in under-resourced countries.

A unique focus of this book is on its case approach to leadership and its use of contributing authors and emerging leaders from around the globe to expand our thinking about what APN leadership actually is and how it will sustain the health care system going forward as the role expands and changes the face of nursing globally.

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Part I

Introduction

Twenty-First Century APN Leadership

1

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This is an incredibly exciting time to be an advanced practice nurse (APN)— In the U.S. this includes nurses who specialize as a clinical nurse specialist, nurse anesthetist, nurse midwife, or nurse practitioner. APNs have an unprecedented opportunity to take on roles throughout the world that expand access to care and more systematically address the root causes of poor health.

Policy-makers increasingly recognize that APNs, as primary providers of health care to people, families, and communities in all settings, offer untapped potential for helping people to live healthier lives. Two seminal reports will be released in 2020 that will underscore nursing's potential to improve health: the World Health Organization's (WHO's) State of the World's Nursing report and the United States' National Academy of Medicine's *Future of Nursing: 2020–2030.* In addition, the 3-year *Nursing Now!* Campaign, run by the WHO and the International Council of Nurses, aims to raise the status and profile of nurses and to empower nurses to take their place at the heart of tackling twenty-first century health challenges. The WHO is further shining a spotlight on the nursing and midwifery fields by designating 2020 the Year of the Nurse and Midwife in honor of nursing pioneer Florence Nightingale's 200th birthday and to emphasize that nurses and midwives are essential to the achievement of universal health coverage. In addition, the International Council of Nurses will soon release definitions of what constitutes an NP and a CNS.

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This focus on nursing underscores that the time is ripe for APNs to take on leadership roles to address the systemic health challenges of the twenty-first century. In fact, the United Nations' Sustainable Development Goals (SDGs) offer an unprecedented opportunity for APNs to be part of the solution in addressing many of the challenges that our world faces, such as poverty, inequity, climate change, and environmental degradation (SDG USA and Sustainable Development Solutions 2018). The goals are aspirational: They imagine a far better world than the one we inhabit today, where all people have access to health care, enough to eat, and an opportunity to thrive. By placing health at the center of creating a more just world, the SDGs offer APNs the potential to lead our world to a better future.

As providers who diagnose and treat people, APNs understand the needs of the people and families whom they serve. They are crucial to expanding access to primary care, especially in underserved areas (Buerhaus et al. 2015). Nurses are consistently named the most trusted profession by Gallup (Brenan 2018) and are everywhere: in our communities, schools, businesses, homes, and hospitals. They are educated to see each person for whom they care in the context of his or her life—all the factors that impact that person's life and well-being. Indeed, APNs have a responsibility—by virtue of their education and training—to sit at policy-making tables and to take on leadership roles in their work settings and communities. Their leadership is needed to improve health and health care worldwide, and to build a Culture of Health that provides everyone a fair and just opportunity for health and well-being.

Despite their skill set and potential to improve care throughout the world, the United Kingdom's All-Party Parliamentary Group on Global Health's *Triple Impact* report in 2016 stated that "nurses are often not permitted or enabled to fulfill their true potential. Cultural, regulatory, and legislative enablers and barriers need to be identified and removed and good practice shared and acted on" (APPG 2016). Indeed, 6 years earlier, the United States' esteemed Institute of Medicine recommended that APNs "should be able to practice to the full extent of their education and training" (Institute of Medicine 2011). APNs in the United States have made progress in removing barriers to practice, and APNs in the United States and throughout the world need to continue to push for the removal of these barriers to expand access to high-quality health care and increase consumer choice (Campaign for Action 2018).

As APNs successfully remove barriers and take on greater leadership roles, they will become important partners in addressing the myriad of global health challenges that abound due to scarce resources, the rising burden of chronic diseases like diabetes, and the impact of emerging factors such as climate change and migration. Health systems are under strain due to aging populations and the spread of western lifestyles. The world has seen a rapid rise of noncommunicable diseases such as diabetes and heart disease. Infectious diseases like HIV/AIDS and malaria plague poorer communities (APPG 2016). Health inequities—which keep everyone from having a fair and just opportunity to be as healthy as possible—are prevalent throughout the world. Removing health inequities will require dismantling poverty,

structural racism, and discrimination (National Academies of Science, Engineering and Medicine 2017).

At the same time, demographic shifts and socioeconomic influences are fostering greater expectations of health care, particularly in higher-income nations, driving from the health care needs of aging populations and the wants of better-informed health care consumers. The health sector continues to be further shaped by government regulation, workforce diversification and shortages, technological advances, and increased engagement from consumers. Critical changes are occurring in health care pricing and attendant views on the appropriate balancing of quality, safety, and costs are adding friction to the dialogue. Fundamental changes in the business of health care will continue to occur, driven by new technologies and heightened patient expectations.

To make the most of this moment and to overcome the health challenges affecting our world, APNs need to utilize their unique skill set and step up to lead. The following list identifies skills that APNs should cultivate to lead effectively.

Foster interprofessional collaboration and form multi-sector partnerships. Care coordination and team work have become increasingly important in providing exceptional care to people as delivering care has become more complex across multiple settings. The landmark Institute of Medicine report, *The Future of Nursing: Leading Change, Advancing Health,* stated that "developing well-functioning teams" is a "crucial objective throughout the health care system" (IOM 2011). Effective coordination and communication among health professionals can improve quality and patient safety (Corrigan 2005). Health professionals working together as integrated teams draw on individual and collective skills and experience across disciplines, allowing each provider to practice at a higher level and provide better patient care.

Similarly, no individual, organization, or initiative can address these complex social challenges alone. Since health is shaped by the stability and safety of our housing, the quality of our schools, and availability of clean, safe, open spaces in our communities, successful health leaders in the twenty-first century will need to be collaborative and invest in multi-sector partnerships that include businesses, government agencies, community groups, schools, and traditional health care institutions. Trust and teamwork will be paramount: successful partnerships will be based on cooperation and not competition. Leaders of multi-sector partnerships must communicate effectively and continually seek feedback from the community. They must engage in boundary spanning leadership, defined as "the capability to create direction, alignment, and commitment across boundaries in service of a higher vision or goal," (Yip et al. 2009). In other words, strong leaders must be able to work across the hierarchical barriers within organizations and the horizontal barriers across organizations, as well as to navigate the different needs of various stakeholders, and demographic and geographic boundaries.

APNs are well-suited to foster interprofessional collaboration and form multi-sector leadership roles. Nurse leaders are almost without peer regarding the need to collaborate and communicate professionally. They routinely engage with physicians, within interdisciplinary and patient-care teams, with social agencies, and

with patients, their friends, and family. These collaborative demands account for the ability of nurse leaders to swiftly and meaningfully develop high-trust relationships.

Political and policy competency skills. Successful twenty-first century health leaders must also develop the political and policy competency skills to implement health-promoting policies and to advocate for changes that give everyone a fair and just opportunity for health. More APNs will need to sit at policy-making tables and boards and use their voices to emphasize policies that benefit people, families, and communities—whether it's helping others to live the healthiest lives possible, to manage chronic conditions, or to die peacefully. The *Nursing Now!* Campaign is working with partners to champion influential leadership roles for nurses and midwives that enable them to apply their own experiences, as well as evidence and data, to make policy changes and improve health care delivery.

In addition, more APNs need to advocate to practice to the full extent of their education and training at the regulatory and institutional levels. Institutions in the United States, for example, regularly make decisions about who will practice within their walls, and insurers make decisions about who will be paid for delivering which services. Insurers may or may not credential APNs. Perceptive APNs may choose to only accept positions at hospital and medical practices that bill for their services. APNs in the United States can get credentialed as a provider, so that they can bill under their own number—or NPI. That way, the health outcomes of their patients will be visible. All APNs should share their stories about how scope-of-practice restrictions hinder their ability to provide full access to care, and work with physicians to build a workforce that is more responsive to communities' health needs.

Entrepreneurial and business savvy. Strong health leaders in the twenty-first century will need to forge new paths and take risks and possess strong business skills. Nurses serving on boards admit that they lack the preparation for assessing organizational finances (Sundean et al. 2018). Nurses need to understand the business and financing of healthcare in their country and how financing affects their role and practice. They also need not only to know how to work within their organizations but also to push the bounds of their role for the sake of better patient care. A great example is Danielle Pendergrass, a *Robert Wood Johnson Foundation Breakthrough Leader in Nursing* and a women's health nurse practitioner with more than 20 years of nursing experience. She fulfilled a "wild dream" of opening her own practice in rural Price, Utah: Eastern Utah Women's Health. Her clinic sees more than 3500 patients and offers services to more than 20,000 women in three rural counties. Before she opened her clinic, many women in her three-county region had gone years without cervical cancer screenings and birth control. Her clinic partners with federal, state, and local agencies to provide care for both the insured and uninsured. She works with the local health department for cancer and health screenings, suicide prevention, opioid addiction, and health-related activities, and with a local university to provide campus health services. Her clinic partnered with a local behavioral health agency to become Utah's first integrated behavioral and physical health clinic. The clinic has collaborated with therapists, social workers, pharmacists, law enforcement, judges, attorneys, and

elected officials. Pendergrass also helped to change Utah's Medicaid policy to permit nurse practitioners to bill and be reimbursed by Medicaid directly. She helped to negotiate equal pay for equal services to enable all nurse practitioners in Utah to be paid at the same rate as the physician rate (Gold 2017).

Compassionate. Health leaders must make a human connection and bring compassion to patients and their families, as well as the communities that they serve. The essential distinguishing feature of a nurse is her or his ability to make a human connection. APNs get to touch another person's soul with each patient interaction. It's a gift. Compassion and excellent clinical care must be central to the care experience. The evidence shows that when patients believe that they have a good care experience, health care organizations also experience lower readmission rates, shorter lengths of stay, lower rates of hospital-acquired conditions, higher patient safety indicator scores, and higher patient engagement scores. Costs decrease and outcomes improve (Smith et al. 2013). Nurse leaders have similarly noted that activities focused on engaging families have resulted in increased patient experience scores and decreased lengths of stay and medication errors (Hassmiller and Bilazarian 2018).

Seek Out Mentoring. Leaders are made, not born. The IOM reports states that "leadership is…fostered through effective mentorship opportunities with leaders in nursing, other health professions, policy and business" (IOM 2011). In fact, mentorship is considered one of a handful of key leadership development best practices (Health Leadership Competency Model 2018). The Health Leadership Competency Model suggests that mentorship facilitates growth in the "enabling" domains that touch on values and self-development of future leaders:

> The most effective mentors share their knowledge and experience, offer new ideas and perspectives, are patient and enthusiastic…We can't teach experience, but we can teach perseverance and the importance of scholarship, ingenuity and enterprise. We *can* teach resolve and conviction. And even if it can't be taught, a mentor must emphasize the importance of character (Loop 2009).

Whether this mentorship is framed as a formal construct or as an informal relationship, its fundamental value lies in situational awareness, experience, engagement, and vision. Support delivered regularly and over time can significantly influence a person's career path. Mentoring enables nurses to become better at caring for patients, families, and communities, and it builds a bridge for other nurse leaders.

APNs that are collaborative form multi-sector partnerships; exhibit political and policy-making skills; are entrepreneurial and compassionate; and seek out mentors and mentor others, thus offering a powerful solution to addressing the global health challenges affecting our world. Properly deployed, APNs have the potential to expand access to care, promote health, coordinate care, and partner with other leaders to address poverty, inequities, climate change, environmental degradation, and to promote peace and justice in order to give everyone a fair and just opportunity for health. As 2020 ushers in the Year of the Nurse and Midwife, it is time to capitalize on the potential of APNs to improve health for all.

(Editors' Note: To honor our belief that mentorship is a critical component of leadership development, we asked emerging nurse leaders to co-author a chapter with each established leader(s). Dr. Hassmiller invited one of her former interns, Ariya Kraik, RN, a student pursuing her master's degree in healthcare management at the T.H. Chan School of Public Health at Harvard University, to share her reflections on nursing leadership as part of this introductory chapter.)

1.1 An Early Career Nurse Reflects on Leadership in Health Care

Ariya Kraik

Health care is unlike any other business endeavor in that individuals in need of care must trust that their needs will not only be considered, but be made paramount. The call for effective leadership, then, is perhaps most critical in health care, given the uniqueness of its mission: health care deals in life and death and delivers a less tangible, more humanistic product than other sectors—namely, improved health and well-being. Leadership in health care must be guided by the primacy of patient needs, which is why it must embrace and deploy the experience, skills, and insights of nurse leaders who already possess many of the competencies required for effective leadership.

As we consider what makes an advanced practice nurse a great leader, I share my own early career experience in leadership development. Just a short while into my own nursing career, I have benefited from interactions with nurse leaders of all kinds—including APNs. My experience is that the best approach to developing your leadership skills as a health care professional is to actively seek development opportunities that push professional limits, deliberately cultivate mentorship relationships, and to observe the examples and approaches of those nurse leaders who exemplify the best qualities of effective leadership. Necessarily, these principles must be framed by a guiding set of personal values, the drive and willingness to take career risks, an interest in forging connections, and especially, a fundamental interest in the care and betterment of others.

My entry into the nursing profession was predicated on a mix of altruism and pragmatism. I was sufficiently practical that I wished to be able to make a decent living as a working professional, but my motivation was an idealism that wished to make the world a better place. Intent on complementing clinical training with an understanding of the broader context of the health care system, I attended the University of Pennsylvania and bridged studies in nursing and business, earning degrees in both nursing and health care management and policy, from the Wharton School. Those rigorous and challenging years were incredibly formative for both the development of my view of the nursing profession and the characteristics of leaders' best equipped to lead in an era of advancing health care. My first year of university coincided with the release of the Institute of Medicine's landmark report, *The Future of Nursing: Leading Change, Advancing Health*, which outlined a blueprint for how the profession of nursing must change to best support an efficient

and effective health care system and ultimately enable the best care of patients. Only a few months into my nursing education, I secured an internship at the Robert Wood Johnson Foundation (RWJF) working with Susan Hassmiller, RWJF's senior adviser for nursing. As Dr. Hassmiller also serves as the director of the *Future of Nursing: Campaign for Action*, I was able to help develop strategies to advance nurse leadership in support of the *Campaign's* leadership pillar and had discussions with industry leaders about being an effective leader and career preparation for leadership; we also worked to develop a business case advocating for the inclusion of nurse leaders in senior management and board governance in healthcare—roles that are vital for APNs as they seek to make significant contributions to health and health care. Dr. Hassmiller encouraged me to envision and embrace a broader future of nursing leadership. I began to better appreciate how Penn's dual-degree program was providing me with insight into both the "head and heart" of health care in the United States. From my time at RWJF, I learned of the need for vision, empathy, and openness to new policy directions, of critical social and structural shifts, and of the dynamics of institutional change.

Following graduation, while most of my dual-degree peers steered toward consultancy or pure business roles, I opted for a more traditional health grounding. I joined the Hospital of the University of Pennsylvania (HUP) as a registered nurse, where I gained three-and-a-half years of clinical experience in diverse settings. Then, as now, I sought increasing professional challenges and rich learning experiences. My time spent in direct patient care underscored the operational pieces critical to providing optimal patient care and a view of how nursing experience could be foundational for any foray into health care leadership. I took on responsibilities and leadership as a charge nurse and preceptor for new-to-practice and student nurses. Away from the bedside, I participated on nursing leadership committees, both unit-specific and hospital-wide, and was involved in research projects. These experiences helped me to understand the layered human dimensions that attach to modern healthcare delivery. On the business side, I was reminded daily of challenges that involve finances, staffing, and effective patient-centered care.

Driven by the wish to learn more about health care and policy, I pursued a master's degree in health care management at the T.H. Chan School of Public Health. During this program, I completed an invaluable internship at the Mayo Clinic in Rochester, Minnesota, where I actively participated in meetings and project work concerning the improved hospital operations of one of most highly regarded health care systems in the world. At Mayo, I learned about effective health care leadership, witnessing how an organization can sustain a legacy of clinical excellence while being principally guided by the needs of patients and structured around collaboration and consensus-driven decision-making. In the span of less than a decade, I have been fortunate enough to acquire exceptional academic and professional training, gain invaluable clinical experience, and receive critical insight and the generous mentorship of many leading minds in nursing and in health care in America. This academic and professional journey has reinforced for me just how critical the nursing profession is—and how much we need sustained and perhaps even more formal training for nurse leadership in modern health care. All of this continues to engage both my head and my heart, and propels me forward in my career.

1.2 Conclusion

This chapter has highlighted the key concepts in APN leadership and provides an example of leadership in a nurse at the early stages in her career. The APN role consists of many facets: expert clinician, patient educator, mentor to other nurses and students, consultant, and expert in evidence-based practice and quality initiatives to name a few. This chapter highlights not only the fact that interprofessional practice is the key to the future but also that APNs also can practice in highly independent roles. Navigating this journey to practice at the highest level of one's education and scope of practice requires the kind of leadership that an expert nurse can engender. The leadership described in this chapter emanates from evidence-based clinical practice and is strengthened by expert clinical and theoretical knowledge and a high level of interpersonal communication and systems understanding. Entrepreneurial thinking and awareness of how to influence policy at all levels are essential for APN leaders to excel in their leadership. This book will highlight all of these aspects of APN leadership as it is developing around the world using lessons from a diverse group of experts in the field.

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Part II

Global Perspectives on APN Leadership

This section focuses on Advanced Practice Nursing (APN) leadership from the perspective of three major nursing organizations, which operate in the global sphere, and uses an example from the United States which is the Future of Nursing: Campaign for Action. The chapter by the International Council for Nurses (ICN) examines ICN's historical role, its current and future work in relation to APN in order to improve the health and well-being of individuals and communities throughout the entire world. It also discusses the emergence of the International NP/APN Network as a formal Network of the ICN, which created legitimacy and assisted with the vision of this group. The chapter outlines the vital role that the International Council of Nurses (ICN) plays in supporting the development and evolution of Advanced Practice Nursing. The chapter on Nursing NOW describes this program which leads up to the Year of the Nurse and Midwife in 2020 and is providing leadership to advance and improve the status and leadership role of nursing globally through affiliate groups in many countries in the world. This campaign has advocated for high-level support from governments and the World Health Organization for increasing investment in nursing and includes not only educating more nurses, but also supporting advanced practice nurses. Sigma Theta Tau is an international nursing organization which for many years has been global in its mission promoting professional nursing practice, leadership, and research around the world. To facilitate the access of advanced practice nurses to human and technology resources, professional development and support are essential. Sigma Theta Tau, the International Honor Society of Nursing (Sigma), is well positioned to provide innovative leadership development opportunities as well as to recognize their excellence in practice, research, and teaching. Finally, the chapter on the Future of Nursing: Campaign for Action: U.S. provides an example of the kind of leadership that is needed to move nursing to a higher level and improve its influence and impact on policy. Since its successful launch in 2010, this campaignhas put policy into practice by forming statewide Regional Action Committees which encourage individual states to apply the principles put forth in the report, *The Future of Nursing: Leading Change, Advancing Health.*

International Council of Nurses

2

David Stewart, Annette Kennedy, Madrean Schober, and Martin Duignan

2.1 Introduction

The importance of global leadership in nursing is made clear when we accept that the nursing role in improving health, addressing illness, and preventing disease is universal, regardless of political boundaries, cultures, socioeconomic status, and other variables common in health systems. Moreover, nurses working at advanced practice levels are increasingly being identified as key to improving health care delivery and preventing ill-health (All-Party Parliamentary Group on Global Health 2016; Ireland, Department of Health 2019). The following outlines global challenges affecting Advanced Practice Nursing (APN); ICN's vital role in developing the Advanced Practice Nursing workforce throughout its history; and the establishment of the ICN NP/APN Network.

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2.2 Global Challenges Affecting APN and the Need for Global Leadership

2.2.1 Differing Levels of Scope of Practice

Advanced practice nursing (APN) is at varying levels of development globally. While APN services are established in countries such as the UK, the USA, Canada, and other jurisdictions, such as Israel and China, have fledgling advanced practice services (Koskinen et al. 2012; Parker and Hill 2017; Schober 2014).

The variation in the standards and requirements to practice as an APN can precipitate and compound confusion regarding the role. For example, in the USA, a National Consensus Model for Advanced Practice Registered Nurse (APRN) regulation, focusing on licensure, accreditation, certification, and education, was published by the American Association of Colleges of Nursing in 2015. Despite this model, a wide variation of the scope of practice of an APN still exists even between differing states. This issue is not limited to the USA. There is evidence from Australia (Wilkes et al. 2015), the UK (East et al. 2015), and Ireland (Department of Health 2019) that APN roles are often constructed at local levels in an ad hoc way and lack an organizational consensus of the scope of practice associated with the role (Boyko et al. 2016). When the APN role evolves in response to local population needs to address specific gaps in local or regional health care delivery, this local focus makes comparison of APN services and outcomes more difficult. It also hinders the public and health care providers' understanding of the roles and responsibilities of APNs.

2.2.2 Human Resources for Health: The Global Demands for Health Workers

Global leaders have realized that attention to health workforce development is required so that health services have the capacity to meet the demands of their communities (Aluttis et al. 2014). In May 2019, the World Health Organization projected a shortfall of 18 million health care workers by 2030 (World Health Organization 2019a). This shortage of health care workers will be the deciding factor, which could impede the achievement of Universal Health Coverage (UHC).

Moreover, an escalating requirement exists for health professionals to meet the urgent global challenges of an expanding aging population (Wayne 2019) and the seemingly inexorable rise in noncommunicable diseases (NCDs) (Duignan and Duignan 2017).Coupled with the worldwide shortage of nurses is an increased demand for APNs who can manage more complex care, especially for those populations who are marginalized or who have decreased access to care (Cronenwett et al. 2011). In addition to taking on more complex roles, APNs are being called on to play a larger role in addressing the future demand for clinical services and to assist in filling the chasm which exists in health workforces worldwide (Heale and Rieck Buckley 2015).

2.2.3 Barriers to Working to Acquired Skills and Capabilities

The Institute of Medicine (IOM) published a report in 2011 (Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing 2011) which highlighted the potential for the nursing profession to address the evolving and emerging health care needs of patients. The first key message from this report stated, "Nurses should practice to the full extent of their education and training" (IOM 2011: 4). Despite this report, the APN role continues to evolve in tandem with a confusion around the scope of practice associated with it, with APNs in many jurisdictions prevented from practicing to the fullest extent of their education, training, and competencies and wide variation in the scope of practice of APNs globally (Villegas and Allen 2012).

Opposition by the medical profession to APN role expansion, especially where the role involves autonomous decision-making, represents a barrier to the scope of practice. Although evidence demonstrates a collegial working between APNs and other members of the interdisciplinary team (Ruiz 2020), national level representative medical organizations have resisted increased scope and independence for nurse practitioners. Despite a recognized global shortage of care providers, medical associations around the world have regularly opposed the introduction of NPs describing the evidence to support their utilization as flawed or inaccurate. In some circumstances, medical associations have either sought to impose regulatory standards or resisted rule changes in order to hinder APNs from working to their full scope of practice. A common cited example of this resistance is ensuring that APNs must work under the supervision of a medical officer so that the medical profession can control what the APNs can and cannot do as part of their clinical duties.

Many believe that these types of barriers aim to maintain the status quo and restrict the nursing profession which has traditionally held less authority (O'Grady and Ford 2016). In practice, this restriction limits access to care for patients and has a negative effect on job satisfaction as APNs find themselves unable to embrace and practice to the fullest extent of their scope of practice (Steinke et al. 2018).

2.2.4 Public Image of APNs

Across the world, nurses are considered one of the most trusted professionals. Despite this public trust and confidence, the professions and the public have limited understanding of the roles and capabilities of nurses and, in particular, APNs.

One key challenge for APNs is the language by which the profession is described. The profession has sometimes been described as nonphysician health care providers, mid-level providers, or doctors' substitutes. The words used to describe some of the care provided by APNs are "task shifting" and "expanded scope of practice." These terms do not accurately portray the roles and responsibilities of APNs and are often misleading or detrimental to the work of the profession. For example, it is insulting to be described as something you are not rather than what the profession is.

APNs have an important and unique contribution that they can bring to health. Unfortunately, the messaging accompanying the roles is not supportive to where it needs to be. As such, the public and the health system are not benefiting from the skills and capabilities that APNs can provide.

This section has captured some of the challenges affecting APNs across the world. It is essential that these issues are addressed so that the individuals and communities can benefit from a highly skilled and capable APN workforce. ICN has a pivotal role to play in leading the future of APN across the globe. ICN is well placed to influence the public, policy makers, health systems and other health professionals about the roles and responsibilities of APN. These next sections will focus on ICN's historical importance to nursing and APN and the work of establishing a global network for APNs.

2.3 The Historical Impact of ICN on Nursing and Advanced Practice Nursing

In 1965, the first official Nurse Practitioner (NP) position was created in the USA, led by Drs. Loretta Ford and Henry Silver. NPs were originally described as health care providers who could provide primary medical services with advanced practice nursing skills particularly to areas of need and underserved areas (Keeling 2015). However, advanced practice nursing (APN) predates the formalization of this title by several decades. We know, for example, that nurse anesthetists were practicing in the nineteenth Century, "nurse specialists" in the 1900s and "clinical nurse specialists" in 1938 (Gray et al. 2000). These demonstrate that the idea and practice of APN has a long and established history.

Nursing practice reaching this level is due to a number of factors including nursing's proximity to the patient, demand for services, health needs, and the skills and abilities of nursing advanced through education and clinical experience. Each of these elements has been a concern of ICN from its earliest times.

When ICN was first established in 1899, Ethel Bedford Fenwick stated (Fenwick 1901):

"From its very beginning, ICN has been a leader in influencing the global health agenda from a nursing perspective. Through uniting the nursing profession across the world, it sought to improve health through an educated workforce with the "right to think and judge for themselves, to help and govern themselves." It was considered essential for nurses to be versatile enough to provide prevention services in addition to the promotion of health and in all forms of sickness, both physical and mental.

In addition to promoting the professionalism of nursing and setting the standards for educational preparation, ICN has been instrumental in developing nursing leadership for the health system. A key example of this is the work of the 1915 ICN President Henny Tscherning, who was from Denmark and was the first nurse to hold a supervisory position in a surgical department. She was a passionate advocate for the formal recognition of nursing as a profession and was very clear about the governance arrangements by which nurses should work. She states, "*Nurses should also have a right to participate in decisions on how their work is to be organized. Work must be made more independent for them*." (Petersen 1993). This declaration

was made at a time when decisions regarding the profession were made by the mainly male dominant medical profession. This is a struggle that continues today in many countries where physicians are often set in charge of the direction of the nursing profession and its educational preparation. Indeed, one of the biggest barriers to APN since its formalization has been the vested interests of the medical profession.

In providing direction and leadership, ICN has been pivotal in addressing this issue. This continues in its work today through addressing the public image of nursing and the key policy positions of health and wellbeing. The early pioneers of nursing understood the potential of nursing that could be harnessed as well as the health needs and demands within countries. ICN President Nina Gage (1925–1929) stated that ICN "*stands for the full development… of every nurse which shall best enable her to bring her professional knowledge and skill to the many-sided service that modern society demands of her*" (Höjer 1947).

It was at this time, that ICN provided health policy guidance to organizations, such as the Red Cross, and to governments as communities attempted to deal with key health issues such as tuberculosis, polio, leprosy, influenza, and child and maternal health. The importance of ICN has been that it has served to provide information and evidence to nurses across the world. It has been the essential driver of the foundational elements of nursing since its inception including work on Nursing Service, Nursing Education, Nursing Ethics, Social, and Economic Welfare of Nurses and Legislation.

Most importantly, ICN's work has laid the foundations of nursing practice around the world. This influence on health policy around the globe occurred even before the establishment of the World Health Organization (WHO).

When the WHO was established in 1948, ICN was elected into an official relationship with the WHO. This gave ICN privileges to represent nursing at the highest level of health of global policy decision-making. One example of this work in action is the influence the organization has had in relation to primary health care. ICN established working groups in 1976 to explore nursing's role in Primary Health Care (PHC). The working groups' recommendations include linking PHC with other sectors such as education, public works, housing, communications, and national health systems and the vital role of expanding the responsibilities of care outside of just the medical profession. This work was presented to the World Health Assembly in 1977 and subsequently a Resolution of the "Role of Nursing/Midwifery Personnel in Primary Health Care" was adopted. The following year, ICN sent a delegation to the WHO PHC conference in Kazakhstan. The delegation stated that nurses must be allowed to perform additional functions within health care teams and that nurses must be active participants in the development and implementation of PHC programs. This work strongly influenced the "Alma-Ata Declaration" of 1978, which became the major milestone of the twentieth century in the field of public health (World Health Organization 2019b).

From this declaration, ICN and National Nursing Associations called on governments to value and enable nurses to work as the vanguard of PHC and expand their role. In addition, these organizations called on governments to improve the education and practice of nursing to better meet the needs of communities in order to achieve the desired vision of "Health for All."

The Alma-Ata declaration formed the foundation of global primary health care efforts. Forty years after this pivotal work in 2018, a Global Conference on Primary Health Care was held in Astana Kazakhstan with the aim to endorse a new declaration to refocus efforts on primary health care to ensure that everyone everywhere can enjoy the highest possible attainment of health. ICN in partnership with Nursing Now, which is a three-year global campaign (2018–2020), aims to improve health by raising the profile and status of nursing worldwide, played a key role in bringing the nursing voice to this important event. ICN worked on advising and shaping the agenda and working papers for this event, moderating and presenting at various sessions. As a result, the work of nursing and APNs is strongly promoted within the new proposed Declaration on Primary Health Care to be endorsed at the United Nations Generally Assembly in late 2019.

Today, ICN continues to be the voice of nursing representing over 20 million nurses worldwide. ICN does this through many different events, forums, campaigns, and collaborations. Examples of this include the World Health Assembly, UN/WHO High-Level Commissions, and Global Coalition on Circulatory Health.

As NCDs have taken over as the main burden of disease and mortality around the world, the work of ICN in providing leadership continues to grow. ICN President, Annette Kennedy, has been a Commissioner on the WHO Independent High-Level Commission on NCDs. Her work on this Commission has been instrumental in promoting the role of nursing and in particular the APN in tackling this epidemic. As a result of this work, it is hoped that the governments will invest in APNs to respond to the challenges posed by NCDs.

History and the work being undertaken demonstrate that ICN is a major influencer on global health policy. ICN has profoundly strengthened the nursing profession which has laid the foundations of advanced practice nursing. From the definition of nursing and APN, to the ethical framework by which the profession practices, establishing education standards and its leadership courses, policies and position statements, ICN has been a powerhouse for enabling the nursing profession to be where it is today.

2.4 The International Council of Nurses: Providing Guidance and Leadership for the Advancement of Nursing Practice[1]

The International Council of Nurses (ICN) represents nurses worldwide and promotes the advancement of nursing knowledge in order to move nursing practice forward. In the 1990s, ICN noted the growth of advanced practice nursing (APN) globally while also noting representation was limited to the USA, the four countries of the UK and Australia. Even though ICN leaders observed the development of the APN concept with interest and enthusiasm, they saw a need to increase and expand knowledge of the diversity of APN development.

[1] Madrean Schober, PhD, MSN, ANP, FAANP, Inaugural Chair, ICN NP/APN Network.

In an effort to move beyond the few countries leading the way, ICN saw an opportunity to provide international leadership and guidance. Following formal and informal discussions with key country representatives, ICN launched the International Nurse Practitioner/Advanced Practice Nursing Network in 2000 (now identified as the ICN Nurse Practitioner/Advanced Practice Nursing Network [NP/APNN]). It was recognized in the early stages of the network[2] development that collaboration and linkage with an international organization such as ICN was pivotal to the future success of the network and to APNs worldwide.

The aim of the NP/APN Network was to obtain international and organizational support to follow new trends and development in the field. As a resource for international nursing and health care communities, the Network was structured as a platform to disseminate information relevant to the APN by organizing biennial conferences, biannual news bulletins and supporting ongoing research projects. The envisioned aim was to continue to encourage and move nursing forward while at the same time emphasizing that sensitivity to country context was essential in APN development.

In addition, the ICN recognized the need to promote commonality of language for the APN concept to facilitate international discussion i.e. a blueprint for conversation and debate. In this early stage, it was felt that an APN definition needed to be flexible enough to allow diverse points of view while avoiding the creation of a rigid platform that might excessively restrict this newly emerging field of nursing practice. Through the expertise of members of the Network, international guidelines were developed for a definition, scope of practice, professional standard, and competencies in 2002 (ICN 2008). The decision by ICN to take an official position on APN roles and this level of nursing practice provided a benchmark from which countries could use the definitive information and adapt pertinent sections for APN initiatives and supportive documents.

The ICN APN/NP biennial conferences have continued to provide a focus on the global emergence of the APN along with provision of learning opportunities on clinical topics and policy. Attendance has grown steadily since the first conference in 2000 with countries worldwide bidding for and hosting APN conferences. The Network membership now consists of over 100 countries.

The ICN definition of the APN has been frequently quoted in journal articles, government documents, research projects, and textbooks. In addition, countries frequently quote this definition to present international support when attempting to launch and implement a new APN initiative. International organizations such as the ICN provide the authority and support for an APN initiative in order to convince key stakeholders and health care decision-makers of the benefits of the APN concept for their health care systems and the health care workforce. When a scheme is viewed as part of global advancement for nursing versus only a local or national directive, international backing offers an increased level of credibility.

The interest and excitement associated with APN development is gratifying. The presence of APNs internationally has increased significantly. Even though the initial ICN definition of APN has been beneficial and frequently quoted, the generic nature of the definition has contributed to disagreement and confusion. In response

[2] Network refers to the ICN NP/APN Network.

to this critique, ICN is in the process of reviewing and refining its position to facilitate improved clarity for understanding the APN concept. Expertise was sought from representatives of the Network and coordinated by ICN leadership. Following review by ICN NNAs and additional expert reviewers, revised ICN APN Guidelines are expected to be finalized and translated by the end of 2019/beginning of 2020.

2.5 Conclusion

We now stand at the precipice of great need and great potential in the health of individuals and communities. We face a threat greater than disease: that is the enormity of challenges that affect the conditions in which people are born, grow, live, work, and age. There are growing divides in our communities leading to major inequities and injustices causing even greater differences in health and well-being. The words of Martin Luther King Junior, *"the fierce urgency of now"* are ringing loudly and clearly. With this echo in mind and the weight of the burden and despair, nurses are needed now more than ever to be health leaders within and outside of the health system.

Throughout its long and distinguished history, ICN has been a leading voice addressing both key health and societal issues. It has sought to ensure "quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce" (International Council of Nurses 2019). Within this role, ICN continues to strongly advocate at the highest levels of government and nongovernmental sectors for the need and improved support for APN. In addition, ICN continues to support professional nursing organizations in their pursuit of advancing the nursing profession.

Through ICN's Nurse Practitioner/Advanced Practice Nursing Network with its biennial conference, our APN Guidelines and leadership programs all contribute to strengthening the nursing profession by developing the APN role. If we are to meet the urgent global health challenges we face today, including the predicted shortage of 18 million health care professionals by 2030, we must invest in nursing, ensure nurses are working to the full extent of their education and training, and continue to move forward to advance the profession.

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Nursing Now

3

Barbara Stilwell and Munashe Nyaka

In 2016 the All Party-Parliamentary Group (APPG), chaired by Lord Nigel Crisp and with members from the British Parliament and the House of Lords, published a report which set out their findings about how nursing could meet the goals of Universal Health Coverage (UHC) and the Sustainable Development Goals (SDG). Their report, "Triple Impact. How developing nursing will improve health, promote gender equality and support economic growth" (All Party-Parliamentary Group on Global Health 2016) recommended that there should be high-level commitment both from the World Health Organization as well as governments worldwide, to increase their investment in nursing. That investment should not only result in more nurses being educated and employed but also in nurses being enabled to work to their full potential, supported by legal and regulatory frameworks.

This is where the story of Nursing Now begins. It is an unusual story in nursing because it is about a campaign conceived and led by a British Lord, Nigel Crisp, who was so convinced that strengthening nursing was the key to UHC that he convinced colleagues from many sectors to support a campaign focused on nurses. His far-reaching influence resulted in the Nursing Now campaign being launched by the Duchess of Cambridge who remains the campaign Patron, and with many champions from inside and outside nursing, and indeed the wider the health sector, who are named supporters of the campaign. Lord Crisp has remained influential throughout the Campaign as chair of the Campaign Board and a regular speaker at Nursing Now events. His high profile presence and high-level network undoubtedly gets access for the campaign team to people and places that might otherwise be hard to reach and this is one reason for the rapid success of the Nursing Now campaign. Lord Crisp is an important catalyst for this new story of nursing.

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But the whole story is complex and reflects many societal challenges of this century. Women's attitudes to their careers, to themselves, and to their work–life balance are changing (Beard 2018). Currently, the #MeToo movement provides a sharp edge that encourages women (and men) to resist the old power structures that demean them. The global nursing workforce consists predominantly of women, so it is no wonder that nursing is impacted by shifts in power between women and men.

Young people are finding new voices driven by their own challenges and our connected world (Kirkpatrick Johnson 2001). They too seek better work–life balance, interesting and worthwhile employment and want to participate in the world they see on the internet. Recent research by Deloitte (Agarwal and Bersin 2018) showed that most companies believe their young employees will be retained for less than 10 years, and a similar trend is seen in nursing in some countries, where young nurses are showing a tendency to change jobs within 10 years of qualifying.

Now so much health information is readily available to everyone by searching the internet and while this is highly desirable it is also potentially confusing. Many searchers will need help to understand the implications for their own health of the information they find. The ability to understand health information is not currently commensurate with the ability to find it. Who is, and will be, teaching health literacy?

Also policy makers and budget holders realize that health care will inevitably become more expensive as more technological developments result in better treatments, which in turn lead to longer life and more people living with chronic illness and needing care. Universal Health Coverage (UHC) means that everyone, everywhere has access to the high-quality services that they need, when they need them, at a price they can afford. How will the world make this possible?

3.1 Shaping the Nursing Now Campaign

The underlying forces that make it so hard to overcome the barriers to change in nursing are complex, interactive, and deeply rooted in social and cultural attitudes and practices which themselves vary from country to country. We have no blueprint for success but can identify some common threads among nurses globally which give us clues about how change might happen. The place and self-esteem of women in society is clearly one of them as is the role of young nurses who can be a force for change in many ways.

The Triple Impact report (All Party-Parliamentary Group on Global Health 2016) concluded that a fundamental change was needed in the way that nurses are regarded and treated if they are to be able to play their full role in achieving UHC, and the Nursing Now Campaign built its goals on the strategies recommended in this report. These goals of the Campaign are that by the end of 2020 there will be:

- increased investment in nursing;
- changes in global policy to enable nurses to practice to the top of their license;
- strengthened nurse leadership and influence;
- better evidence of impact; and
- improved ways of sharing effective practice, especially with those who are not nurses.

In developing a strategy to achieve its Campaign goals, Nursing Now uses two interconnected elements—influencing policy globally and supporting action locally. The first requires adopting a high-level influencing approach working with partner organizations and the campaign champions to advocate to politicians, policy- and decision-makers, and organizations at global and regional levels to include nurses at every level of decision-making.

The second involves providing support to partners locally, including ICN member organizations and national Nursing Now groups, to influence policy nationally and support the development of nursing and midwifery in their countries. We want the local groups to create a social movement among nurses and midwives that will support the aims of Nursing Now and result in changes that are sustainable locally.

Underpinning the campaign was the observation by the Triple Impact team that, *'Nursing can and must take the lead on [raising its profile] but cannot achieve [this] without the support of politicians, policy-makers and non-nursing health leaders'* (p5 Triple Impact). Undoubtedly the campaign can leverage maximum value in having champions, including board members, from other professions (such as Lord Crisp). Those champions make the link between nursing and other professions and nurses and decision-makers, but the links are only effective if nurses have a story to tell that compels attention through what it is and how it is told.

Nurses themselves, and occasionally others, have produced many reports on nursing over the years. World Health Organization (WHO) expert committees on nursing in the 1960s outlined similar issues to those of today. Nursing has seen some advances: nurses in many countries are better educated, more competent, and more confident and a large body of evidence exists on which to base nursing practice. Yet often nursing remains invisible outside of nursing.

3.2 Nursing, Midwifery, and UHC

Considerable evidence exists now about nursing and its effectiveness, especially in primary care settings (Refsum et al. 2018) and how this might be applied to develop new cost-effective care models. In 2018, Nursing Now led a review of the challenges and opportunities for nursing in relation to UHC, published in a report from the World Innovation Summit (WISH) Nursing and UHC Forum at the WISH Conference 2018. In order to improve access to health care at national level, we recommend countries focus on five key areas:

- More nurse-led clinics enabling nurses and midwives to work their full potential.
- Employ more specialist nurses.
- Develop more midwifery services.
- Make nurses central to primary health care, providing services and supervising community health workers.
- Support nurses and midwives in health promotion and disease prevention.

The correlation between the presence of skilled midwives and improved maternal and neonatal mortality has been well described elsewhere and as this chapter

deals more with nursing care, the impact of skilled midwives will not be further discussed. However, it is interesting to note that the State of the World's Midwifery report of 2014 (The State of the World's Midwifery (SoWMy) 2014) asserts that appropriately educated midwives who practice to international standards are competent to deliver 87% of essential sexual, reproductive, maternal, and newborn health services, and yet countries have not responded by preparing and employing more midwives. Nurses and midwives face the same challenges to make their evidence more visible to policy makers and to couch the arguments in terms that show compelling reasons to take policy action based on the evidence.

Two main reasons why nurses and midwives have the potential to make an increasing contribution to health and well-being if they can work to their full potential are listed here.

First, nurses and midwives with their biopsychosocial models of practice are ideally placed to provide the sort of holistic, patient-centered care that is needed globally as the number of people with NCDs and age-related comorbidities continues to grow. Nurses' awareness of the importance of context is critical in understanding the culture and customs of the communities they serve and understand how best to tailor service delivery. The WHO High Level Commission on NCDs (World Health Organization (WHO) 2018) report recommends:

> Within a multi-disciplinary health workforce, nurses have especially crucial roles to play in health promotion and health literacy, and in the prevention and management of NCDs. With the right knowledge, skills, opportunities, and financial support, nurses are uniquely placed to act as effective practitioners, health coaches, spokespersons, and knowledge suppliers for patients and families throughout the life course. (p. 21)

Secondly, because nurses constitute the majority of the health workforce in all countries and therefore are most likely to be found in all health care facilities, they are often the first, and sometimes the only, health professional that people meet when they interact with the formal health system. Nurses are well placed to detect early signs of disease and help prevent outbreaks, identify community needs, initiate public health programs, and help tackle some of the wider social determinants of health, though often their pivotal role is overlooked and undervalued (All Party-Parliamentary Group on Global Health 2016).

A 2015 systematic review of approaches to improving the contribution of nurses and midwives to universal access to primary health care (Dawson et al. 2015) showed that implementing national and state policies to increase the supply and coverage of nurses and midwives to improve PHC access were successful in both low- and high-income countries. Furthermore, policy was also found to enable nurses to carry out expanded roles but importantly, to be successful, expanded access to services could only be achieved when investments were made in infrastructure, education, and improvement of working conditions of the health workforce.

The 2015 review also found that when staff took on expanded roles in their work, there was a positive impact on the delivery of health care, but that successful expansion depended on clearly defining roles, and providing additional education and supportive mechanisms for taking on these roles. In addition, incentives, both financial

and non-financial including opportunities for further education and career development, were shown to be important factors for staff retention and performance.

A 2018 Cochrane review that compared what happened when nurses were substituted for doctors in primary care consultations showed that the *delivery of primary healthcare services by nurses instead of doctors probably leads to similar or better patient health and higher patient satisfaction (*Laurant et al. 2018*)*.

Most studies of safety and satisfaction with nurse care have been conducted in high-income settings, although Dawson and others' review also took account of nursing's important role in the care of people with HIV in African countries. Shifting specific tasks to nurses to scale up the care of poor rural dwelling Africans with HIV/AIDS, hypertension, and diabetes had a positive impact on physicians' workload and did result in better disease management for more people (Dawson et al. 2015).

The evidence to support that nurses are central to the delivery of primary health care is clear and unambiguous, and yet change is as slow now as it has ever been. Nursing Now was formed to speed up the pace of change through advocacy, strengthening nurse leadership, especially among young nurses, and making evidence more easily accessible especially to those who make policy decisions—but will that be enough to bring about the changes that are essential if UHC is to be achieved?

3.3 Why Is Change So Difficult?

It is difficult to find a profession that reinvents itself quite as much as nursing. Nursing has proved to be flexible and adaptive as other professions change, as population needs change and as technology makes different models of practice possible and necessary. And yet changes tend to happen in an ad hoc way without really having an impact on long-term health systems design, or formal recognition in legislative frameworks.

Research discussed above shows that successful expansion of roles requires policy support, training, and reward—and yet—as the Triple Impact report reminds us—nurses are often invisible to policy makers.

Nursing Now carried out a study on nurses and leadership in 2018. A global sample of over 2500 nurses reported that both women and men in nursing felt a lack of self-confidence so that they felt unable to speak up in large meetings. Nurses also felt that they lacked authority in decision-making, even when promoted to a higher position. Some reported not having budget authority so that they were unable to make real change (Newman et al. 2019). These barriers to change are structural (and the study found also gendered) and for sustainable and radical changes to occur in the way that care is organized will require addressing these barriers. This may be why nurses find themselves again and again implementing innovative models of practice without recognition and why some of these innovations do not survive. This discussion has come full circle: nurses need the support of policy makers and politicians if they are to realize their full potential and that support has to include a hard look at the structural and gendered barriers that hold nurses back—and perhaps put others forward.

Nurses always work as team members, as do other health workers. As care becomes more complex teams of health care workers with an array of competencies will become both more necessary and more common. But teams have to find a way of working that hears all views and identifies leaders based on need rather than profession. West and Poulton (2009) studied teamwork in primary health care compared to other teams and found that primary health care teams scored significantly lower than other teams on all team functioning factors except in task orientation. They concluded that a restructuring of the organization of primary health care is required if primary health care teams are to develop clearly shared objectives to facilitate the coordinated approach to the delivery of care.

Nursing Now has to find new ways to reach those who make policy in health with the good news about cost effectiveness of advanced nursing practice—and indeed midwifery—so that real structural change can liberate nurses for advanced practice. This is indeed the moment to shift the paradigm for nursing, when the old certainties and ways are being shaken to the core by economic crisis, climate change, insecurity, a deep desire for stronger social solidarity, and the rising clamor of women's voices. We are impelled to tell a new story of health and health care, the aim of the global Nursing Now campaign.

Nursing Now is learning through the experiences of nurses everywhere, told to us through the Nursing Now groups now in over 90 countries. The Campaign has spread quickly through the world and still groups are launching. We have requests from specialist groups, including advanced practitioners, to have their own Nursing Now groups. This approach explains how Nursing Now is changing the story. Through the Campaign, nurses are seeing themselves as activists, not as lacking in self-confidence.

3.4 Is Nursing Now a Social Movement?

A social movement shares a collective identity and is linked as an informal network; social movements are both organized yet informal social entities that are engaged in bringing about a change either in policy or in culture (Christiansen 2009). Since the 1960s, when social movements flourished—think of civil rights actions in the USA or student protests worldwide—sociologists have sought to understand why people got caught up in collective action or what conditions were necessary for social movements to come about.

Four stages of social movements have been identified as:

- Emergence.
- Coalescence.
- Bureaucratization.
- Decline.

Nursing Now is a short campaign of 3 years and in looking at its rapid growth it is useful to think of the first two stages that social theorists have identified to help

us to understand why this movement might result in cultural change, which has for so long eluded nurses.

Emergence: Within this stage, social movements are very preliminary and there is little to no organization. Instead this stage can be thought of as widespread discontent (Christiansen 2009). Potential movement participants may be unhappy with some policy or some social condition, but they have not taken any collective action in order to redress their grievances. Looking at how nursing has developed over decades there has often been discontent, voiced in letters to nursing journals, and even in longer papers and books (think of The *Politics of Nursing* by Jane Salvage, published in 1985). Nursing Now took the social movement for change in nursing to another level by offering a way to organize around a common message, which is to improve health, it is essential to raise the profile and stature of nurses globally. We now have a more clearly defined sense of what could be done to change the status quo.

Coalescence: While it is the analysis of revolutionary social movements that clearly show this second stage, leadership commonly emerges, people become aware of each other and strategies for success are worked out. This is the stage at which the movement becomes organized rather than consisting of random upset individuals.

These first two stages are the most useful in considering the relatively short Nursing Now campaign, which is unlikely to become a formal bureaucratic organization in the future. Informal movements are increasingly common as technology enables movement members to communicate and engage with each other through websites and social media. This is certainly true of Nursing Now, which flourishes globally because of internet connectivity. It is almost impossible to imagine such a movement forming and coalescing prior to the internet.

Could this be the moment for change for nurses? Certainly, we see an alignment of social, economic, and cultural factors, as described earlier, that, arguably are generating renewed interest in nursing. But the evidence to support the effectiveness of nursing is not new, and outside of nursing, has largely been ignored. The social and economic imperatives to take notice of nursing and midwifery as a key contributor to UHC are drivers of change and the new opportunities for global connectivity for nurses and midwives mean that information sharing is possible on a huge scale.

In 2020, we will see the publication of *The State of the World's Nursing*, which is being overseen by the World Health Organization (WHO) and for which Nursing Now and ICN are co-chairs of the steering committee. This is the first time that a State of the World's Nursing report has ever been compiled and it is in part of a result of pressure from Nursing Now and definitely as a result of the interest of Dr. Tedros Adhanom Ghebreyesus, the Director General (DG) of WHO, who is not a medical doctor, but a sociologist. Dr. Tedros was Minister of Health in Ethiopia and oversaw far-reaching health workforce reforms which resulted in improved access to health services through a logical sharing of tasks with appropriate legislation and training for all health workers. Dr. Tedros has unfailingly supported the goals of Nursing Now and has been involved in the campaign, being at the launch in February 2018, and at the young nurses' event in Geneva in May 2019, as well as

attending the ICN Congress in Singapore. Dr. Tedros also appointed a Chief Nurse to WHO after 10 years with no senior nursing position in the organization.

One may argue that the first non-medical doctor to hold the position of DG has fewer vested interests in maintaining the professional status quo that has prevailed in the organization. Change there is steady rather than revolutionary, but change is taking place, with more appointments open to women and to nurses. The *State of the World's Nursing* report will signpost the changes that nursing needs to flourish and should also highlight the actual and potential contribution of advanced nursing practice to UHC.

3.5 Becoming Visible

The Nursing Now group structure is offering nurses everywhere the chance to become advocates for their own future, and the opportunity to have their national data in *State of the World's Nursing* will give them the chance to present a manifesto for change, based on evidence, to their Ministries.

Nursing Now has recognized that in this process of social change, young nurses are critical. Young nurses are different from older generations—their expectations and ambitions are broader and they want the opportunity to be visible in their own countries and in global health. Nursing Now is working with young people to provide them an opportunity to be visible in global health.

Before the Nursing Now campaign, young nurses were largely unrepresented on global health platforms and at global health events despite other health professions having strong young professional engagement. From the beginning of the campaign, Nursing Now has increased the visibility of young nurses first by having two young nurses selected to be on the Nursing Now board, and then by asking every Nursing Now group to include young nurses in their stakeholders. Young nurses have been given a platform to contribute to this social movement.

The eventual evaluation of the Nursing Now campaign will include scrutiny of what and how young nurses have contributed, but at the halfway point of the campaign, there are some notable developments. We must acknowledge that the contribution of youth to social change in the twenty-first century is more noticeable than in previous times (https://hbr.org/2019/03/young-people-are-leading-the-way-on-climate-change-and-companies-need-to-pay-attention). One example is the support for climate control and environmental concerns: in 2019 on March 15, in what may be the largest youth-led protest in history, an estimated 1.6 million students in 300 cities around the world walked out of school to march for climate action. Another similar march occurred on September 20, 2019 coinciding with the visit by Greta Thunberg, the 16 year old Swede, who has attracted global attention for her call to action on climate change by attending the United Nations General Assembly in New York to speak.

What Nursing Now has offered young nurses is a global platform to advocate for health and their profession, and young nurses have enthusiastically embraced this opportunity to participate, engage, network, learn, coordinate, aspire, and build

a movement themselves. Through local groups, and by engaging on global social media platforms, young nurses have had the opportunity to interact with leaders, both in the profession and in the broader health community, in ways they could not have done before the campaign. This has given young nurses opportunity to learn, network, find mentors, and coordinate themselves to be activists as well as develop professionally.

By explicitly raising the status and profile of nursing, Nursing Now appears to be increasing motivation among young nurses to progress their careers. The campaign offers hopes for increased recognition of nurses globally, better social status, improved working conditions, better remuneration, greater autonomy for nurses, opportunities for career progression including entering into management and leadership. Through the improved social status and profile of nursing, young nurses are keen to explore interests within the different specialties in nursing and to seek opportunities to further their careers.

How motivated are young nurses to stay in the profession

Munashe Nyika, Young Nurse, Board Member, Nursing Now

Entering the profession for different reasons, young nurses like other young people look for a career path that will give them a good job, with a rewarding income, in which they are able to impact change and make a difference in the society they live in and achieve satisfaction about the work they do. A career path in which they are able to achieve self-fulfillment, develop new ideas and new solutions, implement changes they feel would benefit the systems and communities they serve, and contribute to positive gains toward people's living and well-being.

Through raising the status and profile of nursing, young nurses are encouraged to develop their careers and engage with peers on global health platforms. Through NN young nurses have greater visibility and a voice and are able to contribute and be heard in global health discussions. The campaign touches on global health as a specialty among other specialties.

To motivate nurses to stay in the profession will require consistent attention to:

- Address issues within practice such as unemployment, wages, working environments, autonomy of nurses, and gender disparities in leadership.
- Increase the quantity and depth of mentorship programs highlighting the different specialties and giving young nurses an opportunity to rotate between the different specialties in practice in finding their niche.
- Engage young nurses in research so that they develop their skills of enquiry and help them to be part of big projects so they learn how to maintain an evidence-based practice.

3.6 Conclusion

Nursing Now has developed in a social context that is all about changing roles within society—the roles of women, who no longer want to be overlooked or patronized, and of young people who want to be both seen and heard. Nursing, through Nursing Now, has a voice—a new voice that is not seen as complaining but as making arguments for change. And the arguments are supported by evidence.

Nursing practice—especially advanced practice nursing—will take us into the future because it makes perfect sense. Medical science can diagnose and treat what ails us, but we also need a voice to ask what matters to us—indeed in the UK we have now a "What matters to you?" Nurses are perfectly placed to be the health guide which indeed has been nursing's model: we walk alongside the people we meet and treat and help them find the best path. Sometimes this involves technical or medical treatment and sometimes it does not, but it is in the skills to craft person-centered help that nursing has both its art and science. Because it can be difficult to articulate what nurses do in a scientific way—because it involves emotional intelligence as well as an intelligence quotient (IQ), nursing can be dismissed as women's work or just being caring.

The huge need for care in our global society is pushing a new agenda, but so are nurses, who increasingly want a voice, and this movement has impelled Nursing Now as it impels young nurses toward a different future.

We nurses are on the crest of a wave. We have to learn to move with this wave if we are to survive it but the rewards, if we do, are greater respect for our profession and—most importantly—better health for the world.

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4 Developing Tomorrow's Nursing Leaders: How the *Future of Nursing—Campaign for Action* Promotes Leadership

Susan B. Hassmiller, Katharine Eilers, Amy McCarthy, and Carli Zegers

The landmark Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health* nearly a decade ago called for nurses to be full partners, with physicians and other health professionals, in redesigning health care in the United States. "Strong leadership is critical if the vision of a transformed health care system is to be realized," the report states. "The nursing profession must produce leaders throughout the health care system, from the bedside to the boardroom…" (Institute of Medicine 2011). The report stressed that nurses, who are repeatedly ranked by Gallup as the most trusted profession (Brenan 2017) and who spend the most time with patients, families, and communities, bring a unique perspective to leadership tables. Nurses, at four million strong, work in schools, homes, prisons, hospitals, assisted living facilities, and other community spaces; they are well-positioned to be strong partners in building a Culture of Health that provides everyone in the United States, a fair and just opportunity for health and well-being.

Following the report's release, the Robert Wood Johnson Foundation (RWJF), the nation's largest philanthropy devoted to health and health care, AARP, the nation's

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largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older, and the AARP Foundation created The Future of Nursing: *Campaign for Action* to advance the report's recommendations. Promoting nursing leadership is one of the *Campaign's* major goals. *The Campaign* formed Action Coalitions in all 50 states and the District of Columbia. The Action Coalitions are comprised of nurses and a broad spectrum of partners from the health, consumer, policy-making, business, academic, and philanthropic fields.

4.1 Promoting Leadership at the National and State Levels

Nurses on Boards Coalition. Research has shown that few nurses serve on boards of directors, despite their health care expertise. With formal education and training in governance, nurses have the ability to leverage their experiences caring for patients to improve measures of patient experience and quality of care. (Sundean et al. 2019). A recent analysis of health care governance studies found that the representation of nurses on boards of directors has fluctuated between 2 and 6%. These low numbers were attributed to gender disparities and a lack of understanding that nurses are skilled professionals who have a significant impact on the quality and cost of patient care (Prybil 2016).

To address this problem, the *Campaign* launched the Nurses on Boards Coalition, an organization comprised of national nursing and other organizations, including RWJF and AARP. The coalition's goal is to place 10,000 nurses on corporate, health-related and other boards, panels, and commissions by 2020. The Nurses on Boards Coalition counts the number of nurses serving on boards and provides resources to interested nurses to prepare them to serve effectively on boards. As of December 2019, nearly 7000 nurses have reported serving on boards.

Leadership Development Programs: To propel mid-career professionals into senior leadership positions, the *Campaign* launched two leadership programs: *The Culture of Health Breakthrough Leaders in Nursing* program that supported cohorts in 2014 and 2015 and the *RWJF Public Health Nurse Leaders* program that supported a cohort in 2015. The *Breakthrough Leaders in Nursing* program recognized nurses who contribute in extraordinary ways to the lives and well-being of others in their communities. The 20 nurses who were selected received a scholarship to participate in a leadership development program. They also worked with their state Action Coalitions to serve as ambassadors for the *Campaign* and its goals to build healthier communities through nursing. The *RWJF Public Health Nurse Leaders* program provided 25 community health nurses with a 2-year leadership development program designed to contribute to building a Culture of Health. They also worked closely with their state Action Coalitions to build healthier communities. These public health nurses have since become senior-level advocates, leading efforts to direct individuals, organizations, and communities to build healthier communities.

Mentoring Programs: While millennial nurses are largely replacing the many baby boomer nurses who are retiring, an expertise gap persists: new nurses lack the

experience and knowledge of nurses who have been in the workforce for decades (*Charting Nursing's Future*, May 2018). One way to address this gap is to offer newer nurses mentorship opportunities with leaders in nursing, other health professions, policy, and business. In fact, the IOM report states that "all nurses have a responsibility to mentor those who come after them, whether by helping a new nurse become oriented or by taking on more formal responsibilities as a teacher of nursing students or a preceptor" (Institute of Medicine 2011).

Many state Action Coalitions have prioritized mentoring programs to promote nursing leadership. Arkansas, for example, included mentoring as part of its *Young Leaders Program*, which pairs nursing students earning their bachelor's degrees with experienced nurses. Students then complete nurse leadership projects under their mentors' guidance. The Louisiana and Maryland Action Coalitions offer leadership institutes for emerging leaders. Other Action Coalitions, including West Virginia, Virginia, and Nebraska, offer awards to emerging leaders. The awardees from West Virginia also receive mentoring from the state's *40 over 40 Nightingale Award Winners*. The award recipients were selected for dedicating more than 40 years to exemplary nursing practice, education, leadership, and mentoring. At the national level, the *Campaign* has offered webinars on mentoring, including how mentorship effectively prepares nurses for future leadership roles.

Many emerging nursing leaders have benefitted from the *Campaign for Action's* leadership and mentoring programs, including Katharine Eilers, MPH, MSN, RN, an *RWJF Culture of Health: Breakthrough Leader in Nursing; co-chair, Washington Nursing Action Coalition;* and director, Office of Family and Community Health Improvement at the Washington State Department of Health; Amy McCarthy, MSN, RNC-MNN, NE-BC, a board member of the Nurses on Boards Coalition (representing the Texas Action Coalition) and mother/baby nurse manager at Medical City Dallas Hospital; and Carli Zegers, PhD, APRN-NP, FNP-BC, the Nebraska Action Coalition Diversity Committee Leader and 40 under 40 Emerging Leader, and a newly-hired assistant professor at the University of Missouri Kansas City. Here are their stories.

Katharine Eilers, MPH, MSN, RN, *RWJF Culture of Health: Breakthrough Leader in Nursing; co-chair, Washington Nursing Action Coalition;* and director, Office of Family and Community Health Improvement at the Washington State Department of Health

I became a nurse 10 years into my public health career, largely because of the influence of nurses. I was drawn to their practical application of science and service to improve the lives of people, and the way the nursing process naturally overlapped with my population health work. Although I had the pleasure of working with nurses in a variety of settings, it was my experience with two nurses that helped birth my desire to pursue nursing.

The first occurred in the community of South Los Angeles, where I found that it was the trusted nurse at the local clinic who helped us achieve a breakthrough in connecting with parents to improve immunization rates among African American parents. We had been having trouble gaining traction to enhance compliance to vaccinations among parents in the community. Her credibility and care, combined with the dedication of other community-based leaders, made reaching our program goals feasible.

The second was while I was working for an African-founded non-governmental organization conducting food ration distribution to people living with AIDS in a large township on the outskirts of Johannesburg, with almost 100,000 residents living in makeshift, crowded housing. At the time, viral suppression was only possible through the highly active antiretroviral treatment or "triple cocktail." Poverty in this area contributed to malnourishment among people living with AIDS, which complicated the side effects of the cocktail. Our program leveraged food provision as a means to encourage medication compliance among people living with AIDS, but stigma and despair around the disease was a common barrier to their accepting and using their food rations. This nurse leader used her knowledge of the disease, keenly developed skills in persuasion, and sense of humor to gain the trust of and garner hope among the AIDS community. She worked with her team of community health workers as effectively as she did her clients, and it was impactful for me to witness her community health nursing and leadership have such profound impacts. These two nurse leaders remain at the forefront of my mind as I try to embody their spirit and competence.

Although I entered my nursing career in a management position in governmental public health, and had already held different leadership positions in my previous public health career, I view my leadership journey as dramatically deepening once I became involved with The Future of Nursing: *Campaign for Action*. As an *RWJF Culture of Health: Breakthrough Leader in Nursing*, I received intensive exposure to leadership and communications trainings and multiple opportunities to deeply engage in learning about the IOM recommendations on the future of nursing and how they could help to build a Culture of Health. Through national conferences, expert-led trainings, and connecting with nurse leaders from a variety of disciplines on our Washington Nursing Action Coalition, I developed a conviction that part of my duty as a nurse is to simply show up as a leader in a variety of spaces. For me, this meant joining two local non-profit boards, my church board, our state Center for Nursing board, and becoming the co-chair of our Washington Nursing Action Coalition—which perfectly aligned with our Nursing Action Coalition's focus of placing nurses on boards and promoting civic engagement by nurses.

The Washington Nursing Action Coalition has been intrigued with the idea of using our influence as nurse leaders to better position nurses serving in all disciplines and settings to promote a Culture of Health. In partnership with our Center for Nursing, we conducted a baseline statewide survey of nursing knowledge regarding building a Culture of Health, our state's application of the Affordable Care Act, and most fundamentally, the extent nurses knew about the social determinants of health. Through funding from our state Medicaid agency and an investment by RWJF, we developed a video highlighting community health nurses, published articles on nursing's role in addressing the social determinants of health, and then conducted a post survey, which showed a statistically significant increase in nursing knowledge about the social determinants of health. Ongoing funding from RWJF allowed us to begin a multi-year qualitative research study on the role of nurses in addressing the social determinants of health. Our ultimate aim with this project is to work alongside hospitals, clinics, and schools to strengthen a systems approach that

empowers nurses to intentionally address the social determinants of health. Success will require that we continue to skillfully engage partners across systems, including our state Medicaid agency, hospital associations, professional nursing organizations, and ultimately, community-based and governmental service agencies.

The Campaign for Action has helped to give me language and context to more powerfully link my public health expertise with my role as a nurse, and as a result of my involvement in the *Campaign*, my commitment to lead as a nurse has become interwoven into every aspect of my vision for my future. The Washington Nursing Action Coalition has provided a space to practice my leadership and to reach outside of nursing to build a Culture of Health. As I reflect on my nursing career and look forward to next steps, I am confident that the influence of nursing mentors, collaborations with other nurse leaders, and my experience with the *Campaign for Action* have provided the foundation I need to meaningfully address the social determinants of health and systemic inequities. Though inequities seem intractable, together nurses and dedicated leaders from other disciplines can mitigate these problems and make a Culture of Health a reality for our communities.

Amy McCarthy, MSN, RNC-MNN, NE-BC, a board member of the Nurses on Boards Coalition (representing the Texas Action Coalition) and mother/baby nurse manager at Medical City Dallas Hospital

I began my nursing journey in the spring of 2013 after a career in communications and public relations. I had heard about the IOM report in my undergraduate nursing classes and wanted to get involved in transforming the nursing field. I sought out individuals whose paths I admired, reached out to them for opportunities to become involved, and took every chance I could to learn from them.

Dr. Cole Edmonson, the former leader of the Texas Team Action Coalition and chief clinical officer at AMN Healthcare in Dallas, has been one of my most influential mentors. My long-term goal is to become a chief nursing officer (CNO), and I was set on finding a mentor who held this role. Dr. Edmonson was the CNO at Texas Health Resources, where I was a nurse resident. When I discovered that he would be speaking at our graduation, I wanted to meet him. As he spoke to our group, he rhetorically asked the crowd, "Well, who would want my job?"

I instantly raised my hand and said, "I would!"

Needless to say, the response kind of surprised him, but I wasn't deterred. That evening, I emailed him to ask if I could meet with him to discuss his career and avenues I could explore. He quickly responded, and from that point on, we met frequently to discuss my nursing journey, including my decision to join the Texas Action Coalition and assist in its communications efforts. Six years into my career, he continues to be a sounding board for me. Dr. Edmonson took a chance on me early on in my career, challenged me, gave me room to grow, and opened doors I never would have thought possible. I would certainly not be where I am today without his guidance and advice, as well as the support of other nursing leaders who also mentored me.

Once I was connected to the Texas Action Coalition, I helped to design its web content and social media platforms—and loved every minute of it. Utilizing our new online vehicles, we reached members across the state and kept them updated on

state and national trends. I also worked collaboratively with state and national leaders on our statewide Nurses on Boards training workshops designed to educate and prepare nurses for board leadership. In addition, I have developed and facilitated mentoring relationships with nurses within my facility and professional organizations to build bridges among each of the four generations of nurses currently in the workforce. I have encouraged my colleagues to serve on committees and boards within their communities to protect our patients and to help society understand that nurses are fully prepared to lead change to advance health.

For the past 3 years, I have represented the Texas Action Coalition on the Nurses on Boards Coalition and co-chaired the communications workgroup. I have worked with Nurses on Boards Coalition leaders to create marketing campaigns to promote nursing's voice in the boardroom. The campaigns, "Spring Into Leadership" and "Be Counted" garnered national attention and prompted organizations across the United States to seek out nurses for their boards and propelled individual nurses to seek out board positions within their communities. Through my involvement with the Texas Action Coalition, I have developed the confidence, communication techniques, and leadership skills to bring my thoughts and ideas to any table.

As a millennial nurse leader, I have faced generational obstacles on my journey. As I began to seek out new positions, I would frequently be told that I needed to have more years of experience or that my ideas were not in line with the traditional approaches of doing things. It would have been easy to give up in the moments, but I learned to embrace rejection and continued to seek opportunities to lead. Throughout my journey, Action Coalition leaders have served as a listening ear, assisting me as I navigated through these roadblocks. The ability to grow, collaborate, and network with nurses across the state has helped me to develop an out-of-the-box thinking process that has influenced my overall leadership style. I am able to bring my experiences back to the staff I lead within the hospital and help mentor them to think beyond the walls of our unit and to understand the growth and development that is occurring within our profession.

My experiences of working with these organizations have opened my eyes to the opportunities within nursing to shape the future of health care. The key to developing healthier communities across the nation is utilizing our voices through our professional organizations, state Action Coalitions, and board positions, as well as collaborating with professionals both within and outside of nursing. We must develop the motivation and courage to explore options to take our field even further in the next decade to advance our profession and, most importantly, to improve patient care.

Carli Zegers, PhD, APRN-NP, FNP-BC, the Nebraska Action Coalition Diversity Committee Leader and 40 under 40 Emerging Leader, and a newly-hired assistant professor at the University of Missouri Kansas City

(*Editor's note: At the time that Dr. Zegers wrote this, she was a resident of Nebraska and employed at the University of Nebraska Medical Center. After finishing her PhD in the spring of 2019, she was hired as an assistant professor at the University of Missouri Kansas City. She plans to get involved with the Missouri Action Coalition.)*

I was fortunate to begin my nursing career as a participant in the Robert Wood Johnson Foundation and the American Association of Colleges of Nursing *New Careers in Nursing* (NCIN) program, which sought to help alleviate the nursing shortage and increase the diversity of nursing professionals. I was, unknowingly, participating in the Future of Nursing: *Campaign for Action* during its early stages by attaining a baccalaureate degree, gaining leadership skills and helping to diversify the profession.

After graduating, I was hired as a staff nurse in an emergency department. I stayed active in the *Campaign for Action* by being part of a steering committee for developing the NCIN Scholars Network. I am forever grateful for the opportunity to be part of the *Campaign for Action* as a recipient, caregiver, and as a nurse at the bedside and state and national levels.

I participated in the 2014 Future of Nursing: *Campaign for Action* Leadership and Legacy Summit in Arizona—an event that greatly influenced my career trajectory and desire to become a nursing leader. At the time, I had been a nurse for 3 months. The leaders I met from across the country inspired me. Speakers stressed the importance of "BHAG"—or *big, hairy, audacious, goals.* As a first-generation college student, I was successful up to this point by listening to leaders, and this moment was no different. I saw nurses with doctorates leading nursing and health care into the future, and I knew I needed to advance my education. With help from fantastic mentors, I began a PhD and Family NP program.

I also learned the importance of networking and follow-through at that meeting. I met Victoria Vinton, the director of my state's Action Coalition, and Daniel Suarez, the president of the National Association of Hispanic Nurses (NAHN). I applied *BHAG* and pursued the opportunity to promote diversity through the Nebraska Action Coalition and the NAHN, and in my small way, advance the IOM recommendations on the future of nursing and build a Culture of Health.

Over the last 5 years, I have participated in many ways in the *Campaign for Action* and currently serve as the Action Coalition's Diversity Committee Leader. We created and grew the Nebraska chapter of NAHN, developed a diversity toolkit, organized multiple leadership conferences, and started a pipeline pilot program in 2019. The pipeline pilot program is a collaboration among three diversity nursing organizations, as well as the Nebraska Action Coalition Diversity Committee and A Place at Home, a home health company in Omaha. The leadership at A Place at Home worked with the diversity nursing organizations and the Nebraska Action Coalition Diversity Committee to survey its employees to determine how many of their nursing aides were interested in furthering their education. Ten nursing aides expressed interest, and they were partnered with mentors from the three nursing organizations. The nursing aides applied to nursing programs after receiving mentoring and a series of informational lectures on topics ranging from program selection, how to finance their education, and professionalism. The students will continue to receive mentoring throughout the duration of their education program. Importantly, sustainability plans to increase diversity have been woven into every aspect of the Nebraska Action Coalition's work.

My work with the Nebraska Action Coalition served as a springboard that allowed me to develop as a leader in many ways. For example, I collaborated with the *RWJF Culture of Health: Breakthrough Nursing Leaders* to develop a mentorship opportunity for NCIN alumni to engage in state Action Coalition work. I also applied *BHAG* and joined both the national board of NAHN and the national, interdisciplinary board of the Academy of Communication in Healthcare.

I have learned four major lessons from my leadership journey. First, successful leaders share positivity and seek a unified direction. The *Campaign* has been successful in mobilizing nurses because the goals get at the heart of the purpose of nursing—to improve lives and to create a better world. Second, a diverse pipeline is necessary to ensure sustainability. I am a product of this very lesson and see the importance of continuing the mentoring that was provided to me. In addition, diversity of people and thought can strengthen an organization's ability to take advantage of opportunities and confront challenges, as well as build stronger ties to the entire community. The third lesson I learned is that strong leaders make commitments and keep them. Finally, the most valuable lesson from my experience is the impact of strong leadership. I have found that leading from *where you are* is so important. Leadership is not positional, and there is potential for everyone to display leadership in different ways. The most invigorating leaders are transformational, inclusive, and flexible. Through the *Campaign for Action,* I have been privileged to work alongside exceptional nurse leaders from around the nation who display these qualities daily.

The *Campaign for Action* has impacted my career path and the paths of other nursing leaders from across the country. As we look to the future, the *Campaign for Action* will undoubtedly inspire the next generation of nursing leaders to seek a Culture of Health just as it did for me.

4.2 Conclusion

The *Campaign for Action* is fully committed to preparing nurses to serve as full partners with physicians, other health professionals, and other partners both within and outside of health care in efforts to build a Culture of Health. The *Campaign* has worked diligently during the past 10 years to create the next generation of nursing leaders who, as Florence Nightingale aptly said a century ago, "will lead far beyond anything we have done." This next generation of nurses will improve health and our world.

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Sigma Theta Tau International

5

Elizabeth A. Madigan, Matthew S. Howard, and Danielle E. K. Perkins

5.1 Sigma Theta Tau International Honor Society of Nursing

Sigma Theta Tau International Honor Society of Nursing (Sigma) was founded in 1922 by six nurses at the then Indiana University Training School for Nurses in Indianapolis, Indiana, USA. This specialty nursing organization has grown to more than 135,000 active members in more than 90 countries. Organized in chapters that are associated with schools and colleges of nursing, nurses join Sigma as students or as nurse leaders.

Sigma's mission is to advance world health and celebrate nursing excellence in scholarship, leadership, and service. The organization does this through its many programs and services for nurses. Sigma recognizes the value of scholarship and excellence in advanced nursing practice.

5.2 Sigma's Contribution to Global APN Leadership

Sigma has a long history of leadership development for the advanced practice nurse (APN) and in recognizing excellence. For example, in 1996, Sigma organized a web-based conference for APNs. Back then, the technology was still referred to as the World Wide Web, and this kind of opportunity was considered cutting-edge. This web-based teleconference also had possibilities for ongoing discussions in a discussion board type of interface (Graves 1996).

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There is a common misconception that most Sigma members are faculty at universities and colleges. More than 15% of our members identify themselves as APNs. Sigma is a natural "home" for APNs to attend events and programming. Sigma's primary focus areas are leadership, scholarship, and service. Sigma supports nurses over their entire career and provide education at events and during programs that support APN career development and recognize their achievements.

5.3 Sigma's Leadership Academies

Sigma has a long-standing history of developing nurse leaders through scholarship and practice. In Sigma's Nursing Leadership Academies (NLAs), nurses grow and develop their leadership skills. The NLAs focus work on leadership development using Kouzes and Posner's *The Leadership Challenge* as a framework (2017). As part of the program, the participants complete a self-assessment of their leadership skills using the Leadership Practices Inventory©, which is then used by the participants, the subject matter experts (SMEs), and the participants' mentors to design an individualized leadership plan.

As part of the NLAs, evaluations are completed by the participants and the participants' mentors. Outcomes from the programs routinely find that the participants improved in the self-assessed leadership competencies, as would be expected. What is notable is that the mentors improved even more than the participants in their self-assessed leadership competencies. This finding provides an example of a ripple effect for leadership development—the mentors had other participants outside the NLA programs who also benefited from the program, an unexpected and positive effect.

The NLAs support the recommendations contained in the 2010 Institute of Medicine (IOM) report, *The Future of Nursing: Leading Change, Advancing Health* (2011). The report calls for support and development of strong, influential nurse leaders who can fully partner with physicians and other disciplines to impact reform efforts across the healthcare system. These partnerships originate in the practice environment but also include the academic environment (Institute of Medicine 2011).

5.4 Sigma's Practice-Based Leadership Academies

Starting in 2004, with funding from Johnson & Johnson, Sigma developed the Maternal Child Health Nurse Leadership Academy (MCHNLA) North America. In 2008, the Geriatric Nurse Leadership Academy (GNLA) began. Both the MCHNLA and the GNLA used a triad model for leadership development. The triad consists of the participant, a subject matter expert (SME), and a mentor. The mentor does not necessarily have identical content expertise but is an experienced nurse leader who provides the participant with support in his or her leadership journey. The participants work with the SME and mentor over the 18–20 month program on a specific

practice project that is implemented in the participant's work setting. The participants then presented their projects and outcomes at Sigma's Biennial Conventions.

As an example, Pye and Green (2011) report on their project from the 2009 cohort of the MCHNLA focused on APNs in acute care pediatric cardiology. They describe the project's intent: empower the APN team, promote their professional development, and improve retention rates of the APNs. The project components were multifaceted and included a retreat and educational offerings by the team for the hospital staff as well as for the APN team itself. The team noted that empowerment scores increased substantially over the duration of the program (global empowerment from 19 to 23 using the Conditions of Work Effectiveness II instrument) and turnover decreased slightly (from 22.4 to 18.6%). Recognizing the complexity of APN retention, the authors identify that retention is multifaceted and empowerment is only one aspect of the issue.

From Sigma's NLA perspective, these results are consistent with the challenges of making changes in complex systems. Many of the issues that are taken on as projects within the NLAs are complex and multifaceted. Part of the leadership journey for the participants is recognizing that the problems they are addressing are not likely to have simple solutions. Sigma will continue to develop leaders in nursing practice by providing programming that is responsive to the demand for technology, and that is flexible and nimble in achieving broader change impact.

5.5 Sigma's Faculty Leadership Academies

Sigma's faculty leadership development gained momentum through strategic partnerships and funding from organizations and partner universities such as Elsevier and Chamberlain University. In 2010, a leadership academy for novice nursing faculty was developed and accepted faculty into its first cohort. In 2014, an additional leadership academy was developed for experienced nursing faculty and began its first cohort. Academic nurse leaders partnering with their practice counterparts as well as healthcare leaders from diverse disciplines are critical to the translation of "new research to the practice environment and into nursing education and from nursing education into practice and policy" (Institute of Medicine 2011, p. 222).

The faculty academies also use a triad model for leadership development and for supporting the essential faculty roles of teaching, scholarship, and service. The triad consists of the participant, an SME, and a mentor. Like the practice-based leadership academies, the participant works with the SME and mentor over 12 months on a specific leadership development project where the outcome is a project that is implemented in the participant's educational institution.

Specifically, one Sigma faculty academy participant chose to focus her leadership development project on incorporating technology into advanced practice nursing education. Hawkins et al. (2016) the academy triad, supported Hawkins' professional leadership development and project on developing telehealth-focused advanced practice nurse educational partnerships. Upon completion of the project, Hawkins concluded that, "APRN DNPs can assume leadership roles in designing,

implementing, and evaluating telehealth delivery systems that will increase access to care for multiple patient populations" (Hawkins et al. 2016, p. 1). Further, she supports the notion that "all nurses must be leaders in the design, implementation, and evaluation of, as well as advocacy for, the ongoing reforms to the system" (Institute of Medicine 2011, p. 221) as discussed in the IOM report.

In 2015, the first cohort of aspirational and emergent academic nursing administrators set a course to develop their leadership with special attention given to internal and external roles, strategic planning, budgeting, legal concerns, evaluating faculty, emerging donors, accrediting and regulatory bodies, and political issues. Participants bring varying degrees of experience in their roles as nursing program deans, professors, program directors, and nurse administrators. Thus, an SME and mentor form a triad with the participant to provide insight and guidance on the leadership journey. Participants embark on leadership development journeys with leadership projects that are designed to have a lasting impact on their institutions and nursing education.

Development and sustainability of the clinical nurse specialist (CNS) Doctor of Nursing Practice (DNP) program at Michigan State University is the focus of the leadership development journey and project by scholar Jackeline Iseler, DNP, RN, ACNS-BC and her mentor Kathleen Vollman, MSN, RN, CCNS, FCCM, FAAN, as an example. The overarching aim of the leadership project was transitioning the existing clinical nurse specialist program from a master's degree curriculum to an interactive, evidence-based, online Bachelor of Science in Nursing to DNP curriculum. Advancing the educational requirements of CNS's to doctoral level inherently enhances their leadership acumen as well as their ability to have a more significant impact in their care environments via increased integration of evidence into practice.

Sigma's future academic leadership development endeavors will increase the incorporation of technology in leadership development. This is not only critical to reaching global nurses, but its use has the potential to extend Sigma's reach in a way that is transformative for nurses who might not otherwise have access to these resources and information.

5.6 Recognizing Excellence

Recognizing excellence, through awards, is a long-standing aspect of Sigma. The awards are designed to highlight the contributions of nurse leaders and also to communicate to the broader healthcare community the rigorous research and sustained contributions of nurses in scholarship—notably research, teaching, practice, and engagement.

In an early media award, in 2001, Crowther and colleagues developed a hospital-based heart failure program at Jersey Shore Medical Center using a nurse practitioner to run the program (Crowther et al. 2002). Using evidence-based practice principles, the heart failure center demonstrated positive outcomes for hospital length of stay and patient quality of life (Crowther et al. 2002). This program won an award from Sigma, co-sponsored with Nursing Spectrum, to recognize exemplars in evidence-based practice.

Other examples of Sigma's programs of recognition for excellence include Sigma's extensive awards programs where individual nurses are recognized for their contributions to leadership, scholarship, and service. Not surprisingly, many APNs receive awards from Sigma.

Leadership awards vary according to the kind of leadership provided. For example, there are leadership awards for geriatrics and renewal of self and others. Recent examples include:

- Safiya George Dalmida, PhD, RN, APRN-BC, for the 2015 Daniel J. Pesut Spirit of Renewal Award.
- William Rosa, MS, RN, LMT, AHN-BC, AGPCNP-BC, CCRN-CMC, for the 2017 Daniel J. Pesut Spirit of Renewal Award.
- Nancy E. Edwards, PhD, MSN, ANP-BC for the 2015 Amy J. Berman Geriatric Nursing Leadership Award.
  - *Enhancing Mental Health Competencies in Advanced Practice Nursing Graduates* by Edwards and Kersey (2017) led the way in nursing education with their efforts to further develop mental health competence of APN graduates. Specifically, Edwards and Kersey (2017) enhanced the Adult-Gerontology Primary Care Nurse Practitioner curriculum with mental health content and compared it to the existing curriculum. Students reported significantly increased comfort in providing care for elderly patients with mental illness. Confronting the challenges associated with the shortage of mental healthcare providers by enhancing the skill sets of APNs who do not possess specialization in mental health is demonstrative of the kind of leadership that advances patient care outcomes and nursing academics.

Scholarship is also recognized by Sigma through awards. The International Nurse Researcher Hall of Fame (INRHF) recognizes nurse researchers who have achieved significant and sustained recognition for their influence on the profession. In its tenth year, the INRHF has inducted many APNs into its ranks. It is essential to recognize the remarkable contributions made to advanced practice nursing as well as the education of APNs, specifically, by previous inductees into the INRHF. Recent examples include:

- Susan Carter McMillan, PhD, ARNP, FAAN, inducted in 2017.
- Nancy R. Reynolds, PhD, RN, ANP, FAAN, inducted in 2018.
- Marilyn Hockenberry, PhD, RN, PPCNP-BC, FAAN, inducted in 2016.
- Cindy Munro, PhD, RN, FAANP, FAAN, FAAAS, inducted in 2018.
- Cheryl Dennison Himmelfarb, PhD, ANP, RN, FAAN, inducted in 2017.
- Jane D. Champion, PhD, DNP, FNP, AH-PMH-CNS, FAAN, FAANP.
  - Inducted in 2018, Dr. Champion's work has centered on health promotion and risk reduction in vulnerable populations. However, she intuitively merged her clinical practice with her research interests. Dr. Champion's purposeful exploration of issues pertaining to collaborative practice for nurse practitioners (Bailey et al. 2019) and her investigation of clinical competency of Doctor of Nursing Practice students (Christiansen and Champion 2018) illustrate the kinds of diversity in scholarly contributions made by Sigma member APNs.

- Christine Kennedy, PhD, RN, PNP, FAAN.
  - Dr. Kennedy was inducted into the INRHF in 2017. Her contributions to professional practice for pediatric nurse practitioner education (Jackson et al. 2001, 2003), along with her commitment to and advocacy for pediatric populations and their families (Bender et al. 2013; Floriani and Kennedy 2007), demonstrate the leadership and scholarly productivity necessary for significant impact in health outcomes and transformation of healthcare systems.

In accordance with scholarship, Sigma provides specific *research* awards which include the development of new knowledge on a variety of topics related to APN practice and development. Recent examples include:

- M. Cynthia Logsdon, PhD, WHNP-BC, FAAN, for the 2015 Elizabeth McWilliams Miller Award for Excellence in Research.
- Kerry Ann Peterson, PhD, DNP, PMHCNS, PMHNP, for the 2015 Research Dissertation Award, recognizing early career scholars.
- Therese Richmond, PhD, CRNP, FAAN, for the 2017 Episteme Award, recognizing research that has contributed to the good of society and with public benefit.
  - Dr. Richmond, a 2013 International Nurse Researcher Hall of Fame inductee, has published extensively on the impacts of physical and psychological trauma and recovery among vulnerable populations (Giordano et al. 2018; Jacoby et al. 2018; Jiang et al. 2018; Richmond and Foman 2018). Her advocacy for the ethical treatment of patients and research participants also served to inform her receipt of this prestigious award (Richmond et al. 1994; Richmond and Ulrich 2007). In addition to her work with vulnerable populations, Dr. Richmond has made contributions to the science of nursing care of trauma victims. Richmond and Aitken (2011) developed a model "to assist trauma nurses and researchers to consider the injured person in the context of the social, economic, cultural and physical environment from which they come and the long-term goals that each person has during recovery" (Richmond and Aitken 2011, p. 2741).

Practice awards recognize excellence in nursing practice. These awards are consistent with Sigma's mission and vision that focuses on *service*. Examples of recent practice awards given to APNs include:

- Elizabeth Sloand, PhD, CPNP, FAAN, for the 2017 Audrey Hepburn Awards for Contributions to the Health and Welfare of Children.
- Judith E. Haber, PhD, APRN, BC, FAAN, for the 2015 Marie Hippensteel Lingeman Founders Award for Excellence in Nursing Practice.
  - Dr. Haber received the Marie Hippensteel Lingeman Founders Award because of her demonstrated excellence in knowledge and expertise in clinical nursing practice. Evidence of her impact on nursing practice can be

found in her numerous publications on topics ranging from evidence-based practice (Jacobs et al. 2003; Krainovich-Miller et al. 2009) to nurse practitioner competency (Hallas et al. 2012) and interprofessional education (Haber et al. 2017).

5.7 Promoting Scholarship

Scholarship has changed in the past 25 years, with an increasing focus on including more than the traditional research or knowledge generation. The American Association of Colleges of Nursing (AACN) defined scholarship as:

those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that (1) is significant to the profession, (2) is creative, (3) can be documented, (4) can be replicated or elaborated, and (5) can be peer-reviewed through various methods (American Association of Colleges of Nursing 1999, para 5).

In 1995, Sigma also convened a task force to review nursing scholarship and its impact on the profession. The task force noted that clinical scholarship was more of "an approach that enables evidence-based nursing and development of best practices to meet the needs of clients efficiently and effectively" (Sigma 1999. p. 4) Sigma members recognized that scholarship is better described than defined. In 2015, Sigma (2015) revised its take on scholarship, noting the broad expansion and engagement of scholarship activities and recognizing the relevance that multiple disciplines and practice settings bring to the understanding of scholarship.

In 2018, AACN revised its scholarship definition as, "the generation, synthesis, translation, application, and dissemination of knowledge that aims to improve health and transform health care" (American Association of Colleges of Nursing 2018, p. 2). In this dissemination Sigma has become most prominent and has secured a significant presence in scholarship in the global nursing community and is known for a multitude of scholarly activities. These undertakings include Sigma's two highly ranked journals, which disseminate not only research but evidence-based practices. Sigma also promotes APN scholarship through its annual International Nursing Research Congress (among other conferences), the INRHF, multiple publications, and the Sigma Repository.

Sigma has supported nursing research since 1936 when the first research grant for nurses was awarded. Now, Sigma offers grants ranging from $5000 to $20,000 to support nursing scholarship, including one grant specified to support evidence-based practice work. Some grants are co-sponsored with other nursing organizations, and some are open to both members and non-members.

The Sigma Repository is a disciplinary repository that assists nurses and nursing students with all their dissemination (non-peer-reviewed) and publication (peer-reviewed) needs. Its goal is to accept and post a variety of materials that provide nurses, and anyone interested in the nursing profession, with a digital outlet that is unique, free, and global. The repository accepts research materials, clinical-based materials (such as evidence-based practice items and translational research),

educational materials (faculty-to-student, peer-to-peer, expert-to-novice), and corporate materials such as best practices, white papers, and position statements. It brings a variety of resources to a global audience with no access, participation, or viewing fees. It welcomes submissions from Sigma members and non-members. Best of all, submitting authors retain copyright. This effectively expands the reach and impact of the author. Through the repository's internal and external statistical tracking software, such as Altmetrics®, the author can quantify the impact and dissemination of their works. Altmetric® uses online mention tracking technology which features a weighted scoring system across a broad scope of platforms throughout the internet. These benefits not only allow participating authors to assess the influence of their work, the data serve to assist with academic tenure, promotion, and funding endeavors. The following are entries from the Sigma Repository that disseminate the works of APNs:

- Through her presentation in 2018, Dr. Joyce Karl called for APNs to lead initiatives to promote the health literacy of their patients (Karl 2018). She discussed the need for and importance of understanding patient health literacy. In this presentation, provided at the 29th International Nursing Research Congress in Melbourne, Australia, Dr. Karl called upon APNs, who are well positioned to lead initiatives and implement change, to examine their current practice for ways to increase patient understanding and, therefore, compliance with treatment plans (Karl 2018).
- Boyle and Mumba (2018) conducted a systematic review to examine and scrutinize the barriers of APNs attaining full prescriptive authority within the United States. The study noted individual state laws and lack of policy development as primary barriers to increasing APN scope of practice. This presentation provides APNs with specific, actionable items to follow on the journey to obtain full prescriptive authority and expanded scope of practice.
- Jimenez and Thal (2017) presented ways to prepare APNs to think about global health at Sigma's 44th Biennial Convention. This presentation discussed the growing need for APNs to focus on universal healthcare needs. It examined the successful process APN faculty went through to incorporate mission trips into APN curriculum to enrich the lives and outlook of future APNs.

5.8 Global Advisory Panel on the Future of Nursing and Midwifery

Beginning in 2014, Sigma convened the Global Advisory Panel on the Future of Nursing and Midwifery (GAPFON®). The GAPFON initiative had seven regional meetings (Southeast Asia/Pacific Rim, Caribbean, Latin/Central America, North America, Middle East, Europe, and Africa) (Hill et al. 2017). The attendees at the regional meetings represented nurses and midwives from ministries of health, academic settings, practice settings, regulatory bodies, professional and national nursing organizations, and others. The GAPFON stakeholders were asked to identify the

most pressing global health issues and the most challenging professional issues. The final GAPFON report (available at www.gapfon.org) contains the regional results as well as the summary of the regional results synthesized at the global level. There are six categories of findings—leadership (as a core for all categories), policy/regulation, workforce, practice, education, and research—with 93 recommendations (Hill et al. 2017). The recommendations were then further divided into strategies (actionable items) and principles (overarching agreement) (Fig. 5.1).

Advanced practice nursing themes emerged in two strategies at the global level:

1. Under Education, "Develop nursing specialization and advanced practice addressing the health priorities (beyond basic level)" (Hill et al. 2017, p. 40)
2. Under Workforce, "Develop advanced practice roles, including competencies" (Hill et al. 2017, p. 35)

Fig. 5.1 GAPFON model

The identification of only two strategies is not surprising in light of the nascent development of advanced practice nursing in much of the rest of the world. Advanced practice roles are still under development in a number of countries: specifically, the International Council of Nursing Nurse Practitioner/Advanced Practice Nursing Network provides information on APN roles for 14 countries (https://international.aanp.org/Practice/Profiles). The GAPFON strategy on developing advanced practice roles would be an important goal moving forward to support the nursing profession in countries where the role is under consideration or in development.

5.9 Outlook for the Future

Globally, populations of the world are experiencing poor access to care, inadequate healthcare resources, and nursing shortages of overwhelming proportion (Howard and Marshall 2017). Research indicates that patients cared for by nurses prepared at the baccalaureate and higher levels of education experience improved outcomes and higher satisfaction (Institute of Medicine 2011). The overall deficit of nurses, insufficient numbers of those with advanced degrees, high turnover rates, and poor working conditions are factors that adversely affect the nursing workforce (Breau and Rhéaume 2014; Flinkman and Salanterä 2014; Oh et al. 2016; Valizadeh et al. 2016). Ultimately, these factors have grave consequences on the health of the world's peoples. One strategy for enhancing nurse retention and job satisfaction is through the development of mentoring relationships.

Mentoring programs are beneficial to nurses at all levels in their careers, providing personal and professional support, resources, and advice (Harbman et al. 2016). In the United States, ethnic minorities and other underrepresented groups are poised to benefit from formal mentoring programs, as they equalize access to people, resources, and information and are an important aspect of any organization's diversity and inclusion program (Matza et al. 2018; Tabloski 2016). During the 2017 Biennial Convention, Sigma announced a web-based Career Mentoring and Career Coaching program based on the success of the face-to-face career advising sessions performed at Sigma events around the world.

The implementation of a distance-mediated formal mentoring program has been shown to provide the support new nurses need to grow in the profession. Through mentoring, professional progression can occur (Tsui and Girard 2019); further, mentoring has been shown to prevent frustrations that have led to burnout (Katz and Glass 2019) through enhancing communication and professional skills and emotional intelligence (Gandhi et al. 2019). Formal mentoring of health care providers in low- and middle-income countries is needed but can be very challenging (Chi et al. 2019; Hamer et al. 2018) largely due to lack of access to qualified mentors. Sigma's program is designed to bridge this gap through the Sigma's professional networking site: The Circle.

Through the networking site, Sigma has designed the program to advance and encourage nurses to pursue lifelong learning opportunities that will better prepare them to improve healthcare outcomes in academic and/or practice settings. Many

APNs have used the Career Mentoring and Career Coaching program with other APNs serving as mentors.

For example, Miranda Cassity, MSN, APRN, AGACNP-BC, FNP-BC, is both a mentor and a mentee within the Sigma program. In her current practice setting, she serves a rural population in both an acute care and primary care setting. Through her mentoring relationships, Cassity feels she has grown intellectually and academically. The relationships she has fostered through Sigma's mentoring program have increased her knowledge and confidence in her current work as well as her academic curiosity. Because of discussions with her mentor, she is currently enrolled in a doctoral program.

5.10 Conclusion

In summary, Sigma has recognized excellence in scholarship, leadership, and service among APNs for many years. However, recognition for only recognition's sake misses the bigger picture of the contributions made by these APNs to practice, scholarship, academia, and all the roles in which APNs are functioning. With the increasing complexity of healthcare needs globally, nurses, and particularly APNs, are in the perfect position to provide care that is effective and person-centered. Supporting APNs through mentorship, leadership development, and recognition of their considerable contributions to practice, research, and teaching are just a few of the ways that Sigma contributes to global APN leadership.

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Part III

Case Studies in APN Leadership at the Regional or Country Level

This section describes the development of the APN movement in countries in many regions of the world. It highlights how the role developed in each region or countries as part of a region and how leadership helped to move the APN concept forward. Leaders who fostered and developed the role are highlighted as well as successes, continued opportunities, and challenges for the region. The regions or countries included are: Africa, Asia, Canada, Eastern Mediterranean Region, Latin America and the Caribbean, New Zealand, the United Kingdom, the United States. Each of these areas is at a different point of development and has had different experiences with the implementation of APN roles.

For example, the chapter on Canada summarizes research findings on advanced practice nursing leadership and provides exemplars of CNS and NP leadership. Capabilities outlined from a Canadian health care leadership framework are used to examine CNS and NP leadership and to highlight success factors and provide solutions to optimize the leadership potential of these roles.

The chapter on the country of New Zealand describes how over the years nursing leadership has worked consistently and proactively to lobby for and progress the necessary changes in legislation that has enabled NPs to deliver services similar to those of a primary care or family physician and to receive equivalent government funding.

The chapter on the United Kingdom provides an overview of the development of advanced practice in each of the four countries: England, Scotland, Wales, and Northern Ireland. More detail from England is included due to the length and extent of its advanced practice developments.

The chapter on the United States highlights the formation of a national association in the United States to represent all nurse practitioners (NPs) regardless of specialty. From humble beginnings in the mid-1980s, the American Association of Nurse Practitioners (AANP) has grown to 100,000 members representing over 270,000 NPs. AANP continues to be an agent for reform in the US health care system by representing NPs who render high-quality cost-effective care.

Finally, the chapters on Africa, Asia, and Latin America and the Caribbean highlight how the APN role has advanced in these areas with case vignettes and thoughts on how leaders function to implement the role when it is relatively new. They highlight the importance of leadership to leverage and build this role when resources are scarce.

Advanced Practice Nursing in Africa

6

Nelouise Geyer and Christmal Dela Christmals

6.1 Introduction

The conditions that necessitated the introduction of APN programs globally have long been ignored in Africa. Nonetheless, the presence of these practitioners is growing in the region driven by several country dynamics. The proportion of the rural population compared to that of urban areas; the preventable nature of the disease burden; the exclusion of the poor from quality healthcare; and the shortage of medical practitioners and pharmacists are strong drivers for the roll out of APN programs (Ahmed et al. 2011; Christmals 2018; East et al. 2014; Mwangi 2017; Tong 2015). Based on their numbers and proportions within the healthcare system, nurses are well-positioned to transform healthcare to contribute to the achievement of Universal Health Coverage (UHC). Nurses are at the forefront of healthcare provision from primary healthcare settings to specialist hospitals. They have proven capacity to advance primary healthcare (PHC) through expanding access to essential services and health systems will collapse without nurses (Asuquo et al. 2013; International Council of Nurses 2015a, b; Kunaviktikul 2014; Rispel et al. 2014; Rispel 2015; Sanne et al. 2010).

Various examples of APN roles have been documented in Botswana, Ghana, Kenya, Kingdom of Eswatini, Liberia, Malawi, Rwanda, South Africa, Uganda,

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and Zambia, but the scope of practice and legislation to formalize their respective practices are not explicit. General and specialist nurses alike are given task shifting roles rather than being granted autonomy for practice through legislation (Fairall et al. 2012; Terry et al. 2012; Tong 2015; Wolf et al. 2012). Countries in Africa have three governance structures responsible for taking the lead in regulatory reform and establishing educational programs: the office of the chief nursing officer (CNO), the nursing council and the national nursing association (NNA) and this task must be strengthened through collaborative action.

6.2 Development of the Advanced Practice Role in Africa

The development of the APN role in Africa requires committed advocates to champion the process in the face of challenging health systems, other health professionals who may not be supportive of the process, and the needs of the populations dependent on the health services to be delivered (Schober 2016). A few case studies are presented to highlight the progress made.

6.2.1 Botswana

The Ministry of Health of Botswana in collaboration with United States Agency for International Development (USAID) introduced the Family Nurse Practitioner (FNP) program in Gaborone, Botswana in 1981 following the promulgation of the Rural Development Policy (Picard 1979; Joel 2017; Sietio 2000). The 1-year post nursing registration program implemented by the Institute of Health Sciences prepared FNPs to provide primary healthcare services to the underserved rural communities in Botswana where about 70% of the population resides. Kanye Seventh Day Adventist College located in Kanye village about 100 km southwest from Gaborone, also started the training of FNPs in 2003.

The curriculum for the FNP program is currently implemented over an 18 month period (Sietio 2000). The country currently has around 440 Diploma prepared NPs. A Master of Nursing Science specialty program to prepare Clinical Nurse Specialists and was introduced by the University of Botswana in 1996. The FNP specialty was added to the Master's program in 2001. Most of the students in the APN Program in Botswana are part-time students and self-sponsored. Nurses from other African countries also attend the program. Some nurses are sponsored by their governments, international donors, or scholarships to enroll in Masters programs in the United States of America with the aim of the returning to strengthen the human resource base of faculty in the APN Programs.

The Nursing and Midwifery Council of Botswana established in 1966 has opened a register for the APNs. The Council also developed standards of practice, job descriptions, and guidelines for the prescription of medications to expand the boundaries of APN practice.

APNs in Botswana are employed in clinics, outpatient departments of hospitals and school health settings where they provide primary health care services for the

patients and manage chronic conditions like HIV/AIDS, diabetes, and hypertension. The FNP assumes District Health Team roles where they oversee several clinics within the District. Current developments within the APN job space are industries where FNPs provide for the occupational health needs of industrial workers.

6.2.2 Ghana

In Ghana, the development of the APN roles has been very challenging and eventful and not as smooth as reported in publications.

In May 1999, the University of Development Studies (UDS) in Ghana met with a delegation from Canada to initiate a Nurse Practitioner (NP) program. The University of British Columbia, Okanagan, would provide technical assistance with funding from the Canadian International Development Agency (CIDA) (GhanaWeb 1999). The curriculum would be developed by the UDS in collaboration with all stakeholders [Ghana Health service (employer), Ghana Nursing and Midwifery Council (N&MC) (Regulator), and Ghana Ministry of Health (MOH) (policy maker)]. A needs assessment was conducted in 1999 and a Diploma in Nurse Practitioner curriculum was developed. The negotiations with the two major health education and practice regulators [N&MC and Medical and Dental Council (MDC)] were inconclusive before the first group of students was enrolled in September 2001. The UDS implemented the program until 2007 when it was upgraded to a three-year post-registration Bachelor of Science program with the first students graduating with a Bachelors degree in 2010. In 2007, NP graduates formed a coalition called the Nurse Practitioners Group to advocate for the program and the products, but the coalition faded out by 2010.

The leadership brought all stakeholders (UDS, N&MC, MDC) of Ghana, Ghana Health Service, MOH together to resolve the regulatory issues. In December 2013, the group presented a petition to the then minister of health, listing their concerns. Following that petition, the MDC was contacted by the MOH to consider regulating the program. The MDC declined the request citing concerns that the content of the curriculum was more of nursing than medicine and advised that the UDS revise it and take out the nursing components before the council could agree to regulate it. The UDS in response also declined to revise it to suit the MDC's advice explaining that it is an APN program. Subsequently, the N&MC assumed regulatory authority over the program in July 2014, when its Governing Board approved a request for regulation (N&MC 2014). Leaders for this effort who petitioned the Minister of Heath included the Nurse Practitioner Association of Ghana as well as the Nursing and Midwifery Council. On 11th June 2015, the N&MC registered and inducted into practice the first batch of ninety-eight (98) NPs who graduated from 2003 to 2014 (N&MC 2014).The N&MC now conducts licensure examinations for NPs who successfully complete the training. The Ghana Health Services has also developed and adopted a job description to guide the NPs in their practice especially in the public sector. By 2017/2018, the program had produced about two hundred and sixty (260) NPs, many of whom are working and managing health centers across the country while others are working at district and regional hospitals. Discussions

are ongoing for the UDS to consider starting a Master of Science program for nurse practitioners to enable the graduates to progress in their careers.

Even though NPs and the NP program have recently received substantive attention locally and internationally, there were many setbacks. Prior to 2010, no career promotion for NPs was possible. In some instances, employing authorities rejected the NP certificates obtained after successfully completing the program—this was expected because of the lack of accreditation. In other cases, the government employed nurses who gained admission into the program were not granted study leave. There was also no delineation of a career path for general nurses or medical assistants to the NP role, hence limiting the Nurse Practitioner's progress through either career path.

6.2.3 Ghana College of Nurses and Midwives

Leaders from the three major traditional nursing governance structures collaborated in 2011 and instituted a fourth governance structure, the Ghana College of Nurses and Midwives. The College was inaugurated on April 3, 2013. This college has among its objectives to: "promote specialist education in nursing, midwifery, and related disciplines; promote postgraduate nursing, midwifery, and related disciplines for the College; and contribute to the formulation of policies to improve health outcomes and public health generally" (GCNM 2019). The college is in its fifth year of implementing the three-year residency program for postgraduate registered nurses. The college currently has accreditation to implement residency in Pediatric Nursing, Accident and Emergency Nursing, Palliative Nursing, Neuroscience Nursing, Oncology Nursing, Hematology Nursing, Neonatal Intensive Care and Women's Health. Graduates of the college are called fellows and are expected to work as clinical consultants in nursing (GCNM 2019). The fellowship program is clinical oriented. The fellowship is an equivalent to a masters degree but it is not an academic degree.

The college envisions rolling out the following programs in the near future: Ophthalmic, Peri-operative, Critical care, Mental health/Community psychiatry and Public Health Nursing, Nephrology Nursing, Diagnostics in Medical and Surgical Care, Diagnostics in Obstetrics and Gynecology, Cardiothoracic Nursing, Dermatology Nursing, Dental Nursing, Orthopedic Nursing, Medical/Surgical Nursing, Endocrinology Nursing (GCNM 2019).

The fellows are registered with the Nursing Council upon completion of the program. These programs are called specialist programs and not APN programs but the roles played by the fellows are APN in nature.

6.2.4 Kingdom of Eswatini

The Kingdom of Eswatini (formerly Swaziland) is a landlocked lower middle-income country with a population of just over one million. The country has no medical school,

so physicians have to be trained abroad (Kober and Van Damme 2006). The Kingdom experiences a crisis in its human resources for health, which is exacerbated by the very high prevalence and incidence of HIV/AIDS (Dlamini et al. 2018). The brain drain phenomenon in the Kingdom of Eswatini makes it difficult to revolve this crisis. Due to the acute shortage of medical professionals and the primary healthcare needs of the Kingdom, the Family Nurse Practitioner role became imminent (Dlamini et al. 2018).

In 1979, a 1-year certificate program in family nurse practice was implemented in the Kingdom in collaboration with Denmark. The program was suspended in 1995 due to challenges with human resources. This program was not an APN program. The family nurse practitioners were expected to provide Primary Health Care services to clients in variety of settings, focusing on early diagnosis and intervention. A survey undertaken in 2004 highlighted that family nurse practitioners educated in this program, lacked role recognition, which became a source of frustration for the practitioners (Dlamini et al. 2018; Mathunjwa and Potgieter 2004). Furthermore, practitioners were not updated regularly on their knowledge, skills, and attitudes to enable them to provide quality primary health care services to the rural communities (Mathunjwa and Potgieter 2004).

An earlier one-year certificate educational program introduced the family practice role in Swaziland between 1979–1995. This program was presented through a partnership between University of Swaziland and Denmark. Various barriers to this programme contributed to the decision to develop the family practice role at a master's level as an advanced practice nurse practitioner role. The PEPPA framework (Participatory, Evidence-based, Patient focused Process for Advanced practice nursing) (Bryant-Lukosius and DiCenso 2004) provided the context for the development and implementation of the nurse practitioner role in Eswatini starting with stakeholder consultations in 2004–2007. This was followed by role definition, educational preparation and policy/regulatory requirements including the development of a scope of practice. The curriculum was approved by the university in 2016 and the first students were enrolled in 2017. The Global Health Service Partnership (GHSP: a partnership between US Peace Corps, PEPFAR, and Seed Global Health) provided experienced nurse practitioner faculty for a year to support the family practice nursing program until a core family practice nurse faculty could be developed. One GSHP faculty stayed on as program coordinator to provide continuity and expertise to fully develop the program (Dlamini et al. 2020).

6.2.5 Liberia

The Liberian health system was severely compromised by the 1989–2003 civil war followed by outbreaks of the Ebola virus. Many lost their lives or body parts during the war, which required essential surgical interventions. The establishment of nurse anesthetists was therefore a great asset to the nation's healthcare system during and after the war. Mrs. Carmen Gwenigale, a Puerto Rican trained nurse anesthetist, started the Nurse Anesthesia program at the Phebe School of Nursing in 1970, about two decades before the civil war. The program admitted very few students per year and by the time the civil war broke out, only two students were enrolled.

Mrs. Gwenigale had to leave the country because of the war but the program continued for 2 years until the institution had to close in 1990 due to the intensity of the civil war. The Nurse Anesthesia Program was reopened in the year 2000. The training of nurse anesthetists continued until the Ebola outbreak when the institution had to extend holidays for the students until the epidemic was contained (Seed Global Health 2017). In 2016, a non-Liberian physician group instituted a nurse anesthesia training program at the Phebe Paramedical Training Program and School of Nursing where two to six students were trained per annum, but the program curriculum became difficult to implement when the non-Liberian physician group no longer provided support. In 2016, about 73 active nurse anesthetists were providing anesthesia services for the 4.5 million Liberians in 30 hospitals. There was only one anesthesiologist in the country at that time whereas three hospitals did not have a formally trained anesthetist.

Problems that the program currently faces include insufficient full-time faculty, too few clinical training facilities for the students' clinical placement for experiential learning, and funding for the program. The absence of master and doctoral nurse anesthesia programs in the country limits the career progression of the graduates. The college graduates find it difficult to remain in their posts as government salaries are inadequate.

The Global Health Service Partnership visiting faculty, Seed Global Health and Northeastern University Nurse Anesthesia Program (Boston, MA) established a partnership with Phebe Anesthetist Faculty to develop a context-specific competency-based nurse anesthesia curriculum for Liberia. The competencies were based on the International Federation of Nurse Anesthetists (IFNA) standards and core competencies. To stimulate the ownership of the curriculum, the Phebe Paramedical Training Centre School of Nursing faculty led the development of the curriculum. There was substantive involvement of the Liberian Association of Nurse Anesthetists (LANA), the Liberian Board of Nursing and Midwifery (LBNM), the Ministry of Health, and the international partners. The curriculum has been accredited by the Liberian Board of Nursing and Midwifery. The graduates are required to pass a licensing examination organized by the same body before being registered as nurse anesthetists.

6.2.6 Malawi

In Malawi, the APN and Masters programs are skewed toward child healthcare with clinical nurse specialist training focused on the provision of care to children (Coetzee et al. 2016).

The Kamuzu Central Hospital (KCH) is the largest of the four tertiary Hospitals in Malawi with a bed capacity of 1200 beds and the pediatric ward with 250 beds capacity. The KCH collaborated with Seed Global Health to pilot a clinical nurse specialist role in the pediatric ward of the KCH. The program was piloted for 18 months with clinical, staff development, clinical teaching, evidence-based practice to improve the quality and safety of patient care and support nursing students'

clinical education. The clinical nurse specialist role was necessary because of the lack of a well-trained cadre of nurses to provide quality care and clinical teaching for the nursing students on their pediatrics clinical rotation. Clinical activities include ward rounds and patient consultation. Staff development roles were focused on the orientation of new employees and continuous professional development for staff on policies and procedures, teaching roles and preceptorship, whereas evidence-based practice roles consisted of supporting staff in translating evidence to practice. The CNS role in the ward added value to interdisciplinary and interdepartmental collaborations, but the need to revise the roles of the clinical nurse specialist to fit the needs of the pediatric ward became evident. Staff shortage, poor understanding of the clinical nurse specialist roles, and role confusion with the charge nurses' roles were major challenges of the pilot program.

Pediatric nursing training programs in Africa are often benchmarked on European and American textbooks and curricula which are not necessarily context relevant. The University of Cape Town (UCT)'s Child Nurse Practice Development Initiative and Department of Pediatrics and Adolescent Health; Kamuzu College of Nursing (KCN) at the University of Malawi; and the Queen Elizabeth Central Hospital in Blantyre, Malawi developed a context-relevant Masters program in pediatric nursing for Malawi after consultation with the Nurses' Council of Malawi and the Malawian Ministry of Health's Nursing and Human Resources Division (Coetzee et al. 2016). The content of the program focused on clinical, academic, and leadership roles awarding graduates with qualifications in line with the Malawian education framework, registerable with the Nursing Council, and employable by the Ministry of Health. The program has received institutional accreditation and has the capacity of producing 50–60 Masters-level Child Health Nurses yearly.

Queen Elizabeth Central Hospital (QECH) in collaboration with Kamuzu College supported by the Global Health Service Partnership and Seed Global Health have proposed a pilot project to implement a midwifery-led ward within QECH where women who fall within the midwives' scope of practice deliver their child under the care of midwives.

6.2.7 South Africa

The process in South Africa has been slow and arduous. The need to prepare APNs originated in the late 1970s following political unrest that required all white medical practitioners to withdraw from rural and township areas leaving only registered nurses to run the services. In 1985 a legislative provision was made in the Nursing Act, 1978 to enable nurses to assess, diagnose, and prescribe treatment as a special concession when doctors and pharmacists were not available (Geyer 2001). A specialization program is available for their educational preparation. To date the Nursing Council has not amended this legislation to meet the changing healthcare needs of the country. However, the legislation governing education determines that all nursing programs would be located in the higher education sector by 2020, which will ensure a higher level of educational preparation of all categories of nurses. The

SA Nursing Council has aligned the nursing qualifications framework with the education legislation, which for the first time makes provision for the level of specialist and advanced specialist nurse. Only the category of specialist nurse has been formally declared as a category by the Minister of Health.

In clinical practice, nurses and midwives are functioning independently in advanced clinician roles in both the public (primary healthcare, midwifery obstetric units) and private (baby health and immunization services, specialist wound care, home births) sectors. Some midwives in private practice have obtained admission rights to deliver their clients' babies in hospitals. Masters programs and advanced specialist programs are available which prepare practitioners for advanced practice. In the late 2000's government policy changed to allow public sector nurses in clinics to initiate and manage ARV treatment of persons living with HIV/AIDS. This has contributed significantly to increased life expectancy of the population. Educational preparation of these practitioners was mainly through donor funding and the availability of suitable mentors for practitioners who completed the training programs remains insufficient.

6.2.8 Tanzania

Tanzania is an East African country with a population of about 55 million. The nurses in Tanzania have practiced in expanded roles with or without license and supervision due to the acute shortage of medical prescribers. A study conducted in the rural medically underserved regions of Tanzania reported that nurses practice in various expanded roles including regular prescription of medicines for the rural population (Msuya et al. 2017). The study also reported that health care providers across the healthcare spectrum, including nurse leaders, have agreed at a consensus building meeting in 2014 that there is need to provide extra training for nurses through the nurse practitioner program in order to provide quality primary healthcare to the underserved communities. Nursing leadership is committed to developing a legitimate APN role for professional nurses. Most of the respondents stated that the nurse practitioner program should be at the post-registration certificate level. Only a few mentioned Masters level.

In the year 2014, faculty from the Kilimanjaro Christian Medical University College (KCMUCo) in collaboration with faculty from Duke University School of Nursing USA conducted a needs assessment to determine the need for NPs in Tanzania (Mtuya and Blood-Siegfried 2018). They looked at the scope of practice of nurses, the overlap of nursing duties with other healthcare practitioners, perception of nurses' roles from consumers, and the perception of nurses about APN roles. They discovered that 445 nurses prescribe medicines very often due to the absence of licensed prescribers, emergency situations, overcrowding of patients at the outpatient departments and other reasons (Mtuya and Blood-Siegfried 2018). These nurses consist of mainly (51%) enrolled nurses, followed by Diploma trained (42%) and Bachelor degree-trained (7%) nurses. In general, 93% of nurses and

other healthcare providers are in favor of introducing the NP program in Tanzania. In 2018, the proposal for the NP was approved for KCMUCo to pilot the training of nurse practitioners in Tanzania. The program will be a three-year Bachelor program. Currently, staff development and curriculum development for the NP program is taking place by nursing leadership following the approval by the Minister of Health to start a program (Mtuya and Blood-Siegfried 2018).

6.3 Successes, Continued Opportunities, and Challenges

6.3.1 Successes

The credibility of APN practice depends on the educational preparation received, which should distinguish advanced and specialist practice from general practice (Schober 2016) and some of this is seen in the case studies presented. Governments are gradually recognizing the role of the APN programs, probably, due to the current media campaigns and advocacy within the continent (N&MC 2014).

6.3.2 Continued Opportunities

A continuing opportunity over the past years is the interest of the western world to assist African countries to develop and implement APN programs. Collaborative efforts between African and western academics contribute to research on the African context of APN programs and roles. Funding from western organizations and institutions are used for the development of APN programs in Africa (Anathan 2018; GhanaWeb 1999; Mtuya and Blood-Siegfried 2018; Seed Global Health 2017). Some African universities have enough resources that could be leveraged to develop faculty for other countries and institutions as is done with the pediatrics nursing program in Malawi (Coetzee et al. 2016).

6.3.3 Challenges

As highlighted in the case studies, the roll out and education of APNs face many challenges.

6.3.3.1 Limited Resources

Human resources remain a major challenge for the implementation of APN programs across the continent. Looking at the history of all the programs that were designed and implemented so far, international institutions and agencies were the drivers. Poor development of local human resources has failed some of the APN programs. Only a few institutions have the infrastructure and financial capacity to develop and implement APN programs in SSA.

6.3.3.2 Opposition from the Medical Profession

Medical doctors are the heads of ministries and departments of health in most African countries, which gives them extra authority to make policies that oppose the emergence of professional bodies or specialty areas that compete with them for their traditional diagnosis and prescriptive roles. The medical profession seems to think that admission, prescription, and discharge of patients are their birthright and resist the nursing councils who try to extend the boundaries of nursing scope of practice (East et al. 2014) therefore posing the greatest opposition against the introduction of APN programs in Africa (Kolars et al. 2012; Pulcini et al. 2010). The training of lower cadre physicians (clinical officer, physician assistant, and medical assistant), whose training is far less rigorous and shorter than APN preparation, threatens the APN programs (East et al. 2014; INEPEA 2008; Kleinpell et al. 2014; Sastre-Fullana et al. 2014). It is therefore important that nursing organizations undertake radical advocacy to push the APN programs through (Pulcini et al. 2010).

In Africa as a whole, it is a common phenomenon that the more nurses progress in education, the farther they get from the patient because higher practice-oriented programs such as APN were not available, or career pathways do not make provision for upward progress. The only available programs were in education and administration thereby making nurses administrators or nurse educators the most educated nurses.

6.3.3.3 Inefficient Nursing Regulations and Regulatory Bodies

Nursing regulatory bodies lack the capacity and autonomy in many countries to develop the scope of practice of APNs. This creates role confusion among nurses and other healthcare professionals, and leads to placing restrictions on APNs (Duma et al. 2012; East et al. 2014; Kleinpell et al. 2014). Leadership should be strengthened to advocate strongly for progress.

6.3.3.4 Influencing Policy Development

Despite the number of nurses in the healthcare services, their ability to influence national health policy is almost non-existent. The only source of power that the nurses seem to think they have is the national nursing association and unions that can use industrial actions and protests to gain attention from the governments.

6.3.3.5 Lack of Context-Specific APN Benchmark Programs

Many nursing curricula in Africa are benchmarked on western philosophy and textbooks. Nursing research is not well developed in Africa, making it difficult to develop and implement context-specific programs that are responsive to the actual and potential needs of the continent. This is probably the reason why most APN programs are stimulated by foreign institutions and aid (Coetzee et al. 2016; Kolars et al. 2012). Africa needs training and support of local nursing academics and nursing associations to lead the development and implementation of APN programs.

6.4 Role of Leadership in Moving the Advanced Practice Role Forward

Leadership and governance of the nursing workforce is essential in achieving UHC. At the center of these leadership and governance roles is the advocacy of the professional nursing associations and the capacity of the Nursing Councils to create APN registries and license them to practice. The Academies of Nursing must also ensure that CPD programs for the APN are developed to continually enhance their knowledge, skills and attitudes. The current institutional arrangements create the phenomenon whereby the CNOs appointed to advise government on nursing related healthcare policy issues are rather being advised or, for want of a better word, instructed by the Ministers' of Health (Christmals et al. 2019). This makes it very difficult for the nursing profession to push for the APN programs in Africa, especially where the medical profession feels threatened that their monopoly power on diagnosing, prescribing, admission, treatment, and discharge by extension to a massive population of nurses. Most of the ministers of health are medical professionals hence protect the course of medical practice at the expense of the nursing profession and the general population.

For the introduction and implementation of the APN programs in Africa to be successful, there is a strong need for nursing governance institutions to purposefully engage educators, the regulators, and practitioners to develop the APN programs and the legal framework within which the graduates practice using the Nursing Associations.

Locally, the first author of this chapter advocated for the formalization of the APN role by creating awareness and establishing networks with other stakeholders to strengthen the drive to promote APNs in South Africa. At an international level she was involved in the launch of the International Council of Nurses' International Nurse Practitioner/Advanced Practice Nursing (INP/APN) Network in 2000 (Schober 2016). She chaired the first Policy, Practice and Standards Subcommittee championing the development of the work on the scope of practice, standards, and competencies of the APN that was later internationally consulted and published.

6.5 Conclusion

While the development of the APN role has been slow and challenging in Africa, case studies show good examples of progress. Nurses in Africa are performing many of the activities associated with the advanced practice role, with varying degrees of independence and autonomy to manage their own case load. Formal recognition of the advanced practice role in African countries has become vital to make progress toward the goal of universal access of all populations to quality healthcare. Such recognition requires regulatory reforms in most countries to improve access to educational programs at Master's and doctoral level, to improve independence and autonomy, and to develop clinical career paths in healthcare services to retain

expertise in clinical services. The leadership role of nurses and their organizations must be strengthened to not only influence policy development, but also to convince the powers that be of the importance of APNs to achieve universal healthcare for all.

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Advanced Practice Nursing in Canada

7

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The clinical nurse specialist (CNS) and nurse practitioner (NP) are the two types of advanced practice nursing roles recognized in Canada. According to the national framework on advanced practice nursing, both roles are centered on the delivery of direct comprehensive care in combination with competencies required for

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optimizing the health system; educating nurses, health care providers, patients, and families; engaging in research activities; consulting and collaborating; and providing leadership (Canadian Nurses Association 2019). In this regard, CNSs and NPs share many similar role competencies and are identified as clinical leaders in the practice settings, organizations, and communities in which they work. One area in which the roles differ relates to scope of practice for direct comprehensive care. CNSs provide highly specialized and advanced clinical care within the scope of practice of a registered nurse for patients, communities, and populations with complex health and health care needs. NPs have an expanded scope of practice with legal authority to autonomously formulate a diagnosis, order and interpret diagnostic tests, prescribe medications and treatments, and perform procedures. Role specific competency frameworks for the CNS (Canadian Nurses Association 2014) and NP (Canadian Nurses Association 2010) also emphasize leadership as a core dimension of these roles.

In this chapter, we outline research findings about advanced practice nursing leadership in Canada. In addition, exemplars are provided to highlight CNS and NP leadership in response to gaps in health care for underserviced and high need populations, changes in health care legislation, and the need to build capacity to conduct research relevant to advanced practice nursing roles. In applying the domains and capabilities of an established health care leadership framework, attributes of effective CNS and NP leadership illustrated by these exemplars are uncovered. Factors contributing to successful leadership are described along with challenges and opportunities to strengthen CNS and NP leadership in Canada are considered.

7.1 Research About Advanced Practice Nursing Leadership

In general, most published research on advanced practice nursing focuses on the NP role, with limited research on the CNS role (Martin-Misener and Bryant-Lukosius 2016). Similarly, a search of the literature in preparation for this chapter found just a few studies that focused specifically on advanced practice nursing leadership. Most often, studies examine leadership as just one of many components of CNS and NP roles. In this section, the results of several practice pattern studies of CNS and NP roles are discussed in relation to leadership.

In Canada, the LEADS in a Caring Environment Leadership Capabilities Framework is a well-established model that is used by organizations and national accrediting bodies to support individual leadership development and to facilitate transformational change in health care organizations and systems (Health Leadership Academy 2019; Vilches et al. 2016). The framework outlines capabilities in five domains that are required for effective leadership related to Lead Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation (Dickson et al. 2007). The capabilities associated with each of these domains are outlined in Table 7.1. The LEADS framework is highly relevant to the leadership roles of advanced practice nurses. A Canadian qualitative study examined advanced practice nurse perceptions of their leadership capabilities and contrasted these with the LEADs framework. While the analysis did not examine differences between CNSs

Table 7.1 Leadership capabilities—LEADS framework

Leadership dimension	Leadership capabilities
Lead self	• Aware of their own assumptions, values, principles, strengths, and limitations • Take responsibility for their own performance and health • Actively seek opportunities and challenges for personal learning • Model qualities such as honesty, integrity, resilience, and confidence
Engage others	• Support and challenge others to achieve professional and personal goals • Creating engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities • Listen well and encourage open exchange of information and ideals using appropriate communication media • Facilitate environments of collaboration and cooperation to achieve results
Achieve results	• The inspire vision by identifying, establishing, and communicating clear and meaningful expectations and outcomes • Integrate organizational missions and values with reliable, valid evidence to make decisions • Act in a manner consistent with organizational values to yield effective customer-centric service • Measure and evaluate outcomes, compare the results against established benchmarks, and correct the course as appropriate
Develop coalitions	• Create connections, trust and shared meaning with individuals/groups • Facilitate collaboration, cooperation, and coalitions among diverse groups and perspectives aimed at learning to improve service • Employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system • Are politically astute, and can negotiate through conflict and mobilize support
Systems transformation	• Think analytically and conceptionally, questioning and challenging the status quo, to identify issues, solve problems and design, and implement effective processes across systems and stakeholders • Create a climate of continuous improvement and creativity aimed at systemic change • Scan the environment for ideas, best practice, and emerging trends that will shape the system • Actively contribute to change processes that improve performance and service delivery

From LEADS Canada. LEADS Leadership Capabilities Framework. https://leadscanada.net/uploaded/web/Resources/LEADS_Corporate_Brochure_2016_final.pdf. Accessed 4 July 2019

and NPs, two overarching themes were found to describe advanced practice nurse leadership related to patient-focused leadership and organization/system-focused leadership (Lamb et al. 2016). Capabilities related to patient-focused leadership involved managing patient-centered care, coaching and educating, advocating, and initiating meaningful communication. Capabilities for organization/system-focused leadership involved improving care quality, enhancing nursing practice, being an expert clinician, communicating effectively, mentoring/coaching, providing leadership on internal and external committees, and facilitating collaboration. Capabilities that were highly aligned with the LEADs framework emphasized effective

communication, modeling a high level of professionalism, having a vision for nursing, and strategic future-oriented thinking.

A recent national study compared the practice patterns of CNSs, NPs, and specialized nurses in non-advanced roles, the results of which highlight the important leadership contributions of advanced practice nurses for improving nursing practice and the delivery of health care services for organizations and health systems (Bryant-Lukosius et al. 2018a). Compared to nurses in non-advanced roles, both CNSs and NPs spent significantly more time on all six activities related to professional leadership such as disseminating nursing knowledge; acting as committee members on professional associations; providing consultations for professional or lay communities and health care organizations; representing nurses at patient education, institutional and community forums; and shaping health care policy (Bryant-Lukosius et al. 2018a). In addition, CNSs spent significantly more time than NPs in each of these six leadership areas. Related to their expanded scope of practice, NPs spent more time in providing direct comprehensive care than CNSs and nurses in non-advanced roles. In contrast, CNSs had greater role responsibilities for practice improvement and facilitating change and innovation within organizations and health systems, and as such spent significantly more time than NPs and nurses in non-advanced roles in leadership activities related to education, support of systems, and research.

An earlier practice pattern study found that Canadian CNSs reported spending about 18% of their role time providing organizational leadership (Kilpatrick et al. 2013). Leadership activities included advocating for a culture that supports professional growth, monitoring and evaluating care practices to ensure safety, identifying and prioritizing issues to improve the quality of patient care, and advocating for advances in the delivery of specialty services. An important finding of this study was that structural factors such as the CNS reporting to a nurse manager and use of an advanced practice nursing framework to guide role development and implementation were positively associated with leadership activities (Kilpatrick et al. 2016).

A practice analysis study of NPs in Canada indicates that they spend about 6% of their role time in leadership activities (Canadian Council of Registered Nurse Regulators 2015). Leadership activities related to promoting the benefits of the NP role; implementing strategies to integrate and optimize the NP role in health care teams and systems; coordinating interprofessional teams; contributing to health care provider education and learning opportunities; identifying gaps in the system and providing evidence-informed recommendations for change; effective communication skills to negotiate, manage conflict, build coalitions and manage change; policy development; and program planning and development. On average, NPs reported at least monthly involvement in most of these activities, except for more frequent weekly involvement related to health care provider education.

Comparing the results of the three practice pattern studies outlined above is not possible due to the use of different tools and how the domains and activities of advanced practice nurse leadership were defined. However, across the three studies it is evident that leadership is a prominent role activity for both CNSs and NPs. The results are similar to an earlier study (Donald et al. 2010) suggesting that the

increased time NPs spend providing direct comprehensive care can limit the time available for leadership activities, and that CNSs often have greater role responsibilities related to organization and systems leadership. It was also noted that how CNSs and NPs implement their roles, or the balance of work time spent between providing direct comprehensive care and other competency domains such as leadership, is highly variable and influenced by population health needs and the practice setting and organizational contexts in which they work.

7.2 Leadership to Address Gaps in Care for Underserviced and High Need Populations

7.2.1 Nurse Practitioner-Led Clinics (NPLCs)

The introduction of the first NPLC in 2007 in northern Ontario was a landmark achievement led by NPs in that province. The NPLC improved access to primary health care in a region where there were unemployed NPs and over 30,000 people who did not have a regular primary care provider (Heale 2012). The success of this model paved the way for an additional 25 NPLCs (Heale and Pilon 2012). A key component of this model is NP leadership in all levels of the organization, including clinical practice, management, and governance (DiCenso et al. 2010). Governance boards are comprised of at least 51% NP representation (Heale 2012; Nurse Practitioner Association of Ontario 2019). This strong NP leadership governance model allows for nursing influence on policy, procedures, and clinic structure and organization (Heale 2012) to best meet the needs of the community. In addition, NPs are identified as the lead primary providers (Nurse Practitioner Association of Ontario 2019; Virani 2012) and are responsible for leading the interprofessional team which can include collaborating physicians, nurses, dietitians, social workers, pharmacists, occupational therapists, and other health care providers (Ministry of Health and Long-Term Care 2015). Evaluations of the NPLCs have shown that they have reduced the number of patients in Ontario without a primary care provider and are associated with high levels of patient satisfaction and improved chronic disease prevention and management (Heale and Pilon 2012; DiCenso et al. 2010).

A qualitative study examined the attributes and activities of the NPs who led the initial introduction of NPLCs in Ontario (O'Rourke and Smith Higuchi 2016). The analysis outlined a series of strategic activities over a 20-month period to lobby the provincial government to permit NPs to submit an application for funding to establish an NPLC; inform and engage local government, politicians, and the public in their campaign; successfully negotiate a contentious funding offer and agreement with the Ministry of Health; create a business plan and governance board; develop clinic operations; and launch the new clinic with the Ministry of Health and media in attendance. A key success factor was the NPs' dogged leadership and commitment to their vision for an NPLC clinic that challenged the status quo in which only physicians could lead team-based models of primary health care (O'Rourke and Smith Higuchi 2016). Three attributes were found to characterize NP leadership in

this regard: perseverance to continue even when faced with opposition and barriers, risk taking in order to not compromise their vision for the NPLC, and effective communication to articulate their vision of the NPLC to key stakeholders.

These attributes mirror leadership capabilities outlined in each of the domains of the LEADS framework. *Lead Self* was demonstrated by their resilience and confidence to stay the course. They *Engaged Others* and *Developed Coalitions* with key stakeholders to support their vision for an NPLC. The NPs *Achieved Results* by effectively communicating their vision of and the benefits of the NPLC, successfully negotiating through conflict, and taking risks to stay true to that vision. Finally, they provided leadership for *Systems Transformation* by challenging the status quo to introduce a new model of team-based primary health care to address population health needs.

7.2.2 The Acute Care Geriatric Nurse Network (ACGNN)

In 2003, a group of CNSs from a variety of specialty areas including gerontology, geriatric medicine, geriatric psychiatry and rehabilitation, and orthopedics rallied together to establish the ACGNN. The aim of the ACGNN is to improve the care of acutely ill older adults by building a supportive mentorship network among local nursing communities and providing access to CNS expertise not available in many communities in their province (Acute Care Geriatric Nurse Network 2017). In its first year of operation, over 300 nurses from eight communities joined the ACGNN. An initial evaluation of the network demonstrated growth in recruitment of CNSs and nurse participants across regions, a high level of nurse satisfaction related to the clinical relevance of workshops provided, and a positive impact on nurse empowerment and confidence in the personalized care they can provide to older adults and ways that they can improve care delivery in their practice settings (Carr and Hunt 2004).

The CNSs responsible for introducing and managing the ACGNN over the last 16 years have enacted many of the leadership capabilities described in the LEADs framework. In relation to *Lead Self*, they modeled confidence in their abilities as CNSs. They *Engaged Others* by bringing together CNSs with a broad range of expertise to achieve ACGNN goals and effectively communicated their goals to recruit over 300 nurses from their region. They also supported the professional development of nurses involved in the care of older adults by providing meaningful learning opportunities through workshops in the communities where nurses worked, establishing relationships and providing mentorship with these nurses, and developing and providing a range of online evidence-informed clinical decision-making tools (M. Carr, personal communication, May 29, 2019). The CNSs *Achieved Results* by communicating a clear vision and expected outcomes that led to startup funding by the provincial Ministry of Health and also by evaluating the impact of the network. They demonstrated ability to *Develop Coalitions* and establish trust and meaningful

relationships with key stakeholders by recruiting additional CNS collaborators and nurse participants. The CNSs have also been able to sustain the relevance of the program to their stakeholders for well over a decade. Finally, they were instrumental in facilitating *Systems Transformation* to improve the nursing care of acutely ill older adults by recognizing the barriers to providing high quality care and promoting the CNS role and the services offered by the network as important strategies to address these system-wide challenges.

7.2.3 NP-Led Care for Transgender Individuals

Another exemplar involves the development of an NP-led program to provide access to primary care services and gender transition supports for transgender individuals. Transgender individuals represent one of the most underserved and marginalized populations in health care (Alegria 2011; Roberts and Fantz 2014) with up to 40% not having a regular primary care provider (Jenner 2010). This program was developed by an NP in Ontario, in an urban family health team. The gap in services for transgender individuals was identified after the NP met a patient who shared a story of the struggle to find a primary care provider who was open and supportive of her transition. To address this gap, the NP developed a clinical program and put together an interprofessional team to provide primary care services specifically for transgender individuals. The interprofessional team consists of NPs, physicians, a psychologist, a social worker, and a pharmacist. Patients are highly satisfied with the program that now provides care to over 120 individuals. Additionally, the program provides community support and mentorship for other primary care practitioners to increase the practitioner's capacity providing care to this population (E. Ziegler, personal communication, June 4, 2019).

The NP demonstrated leadership capabilities across all domains of the LEADs framework. *Lead Self* was demonstrated through self-reflection and awareness of personal values and assumptions about the health needs of transgender individuals and seeking out opportunities for learning and professional development. Through ongoing mentorship and by providing learning opportunities to support the professional development of the interprofessional team, the NP *Engaged Others*. The NP *Achieved Results* by establishing outcomes and expectations for the program and addressing the health care needs of the transgender individuals. To bring together an interprofessional team and network of community service providers for the program, the NP *Developed Coalitions* by establishing trusting relationships and facilitating collaboration. Lastly, *Systems Transformation* occurred through the NP's efforts to improve access to primary care services and optimize the delivery of patient-centered and interprofessional team-based care for transgender individuals both within and external to the family health team in which she worked. Further, the NP is contributing to new knowledge about the best ways of providing primary care for transgender individuals by leading a program of research in this area (Ziegler et al. 2019).

7.3 Leadership in Response to Changes in Health Care Legislation

7.3.1 Medical Assistance in Dying (MAID)

In 2016, Health Canada, the federal department responsible for helping Canadians maintain and improve their health, approved legislation to abolish criminal laws prohibiting MAID and outlined regulatory requirements and conditions in which MAID could take place (Government of Canada 2019). A significant feature of this legislation is that in addition to physicians, in most provinces NPs are permitted to assess patients for eligibility to receive MAID and also to prescribe and provide the procedure. At provincial/territorial levels, regulatory changes to support NP practice related to MAID also took place, including changes to NP scope of practice giving them the authority to prescribe controlled drugs and substances (College of Nurses of Ontario 2018a). An analysis of documents created by provincial/territorial nurse regulatory bodies outlined the major role and responsibilities of NPs and the supportive role of registered nurses with respect to MAID (Pesut et al. 2019). Since 2016, 6749 Canadians have received MAID, with the numbers doubling in each successive year as awareness of the procedure improved and relevant structures were put in place (Health Canada 2019). Over the last 3 years, the proportion of MAID procedures provided by NPs has risen from 4 to 7% (Health Canada 2019).

Since the introduction of MAID is so new, there is limited published data on the role of NPs. However, the experiences reported to date illustrate the strong leadership role required by NPs to deliver comprehensive patient and family care, and ethically sound and safe care related to MAID. In relation to *Lead Self*, NPs must reflect on and be aware of their own knowledge, skills, values, and beliefs and the role they are personally able to play in MAID. NPs are not obligated to participate in MAID but must refer patients to an NP or physician who provides this service (College of Nurses of Ontario 2018b). Participating in MAID is emotionally demanding work, thus it is important for NPs to take responsibility for their own health by managing the stress associated with this procedure (Andreychuk et al. 2019). To implement MAID as a new procedure, NPs also *Engage Others* to provide relevant education and to facilitate the development of practice environments that can safely support MAID through collaboration and cooperation among health care providers (Andreychuk et al. 2019). They also help to *Achieve Results* through regular reporting on MAID activities and monitoring and evaluating practices and processes to improve care delivery. By creating trust with patients, families, and health care providers, NPs *Develop Coalitions* to continually improve service delivery related to MAID (Andreychuk et al. 2019). NPs have facilitated *Systems Transformation* by problem-solving the challenges associated with implementing MAID (Andreychuk et al. 2019) and by increasing access to this service, especially for patients in rural and remote communities (Bridges 2019). Further, NPs play a critical role to ensure that all patients have good access to high quality end-of-life care to improve their quality of life and alleviate suffering and thus reduce the unnecessary need for MAID for some patients (Booker 2019).

The Canadian Nurses Association (2017) has provided a framework to outline the roles of nurses and NPs who provide MAID services in the context of interprofessional healthcare teams. There is a clear emphasis in the document on the provision of safe, compassionate, competent and ethical MAID services by nurses in different roles (e.g., practical nurses, nurses, NPs) (Canadian Nurses Association 2017). However, similar to the regulatory documents, no role is described for CNSs in the provision of MAID services in the framework (Canadian Nurses Association 2017). Given the highly complex nature of MAID services, the lack of role models for nurses, and important legal and the ethical issues that have yet to be explored in areas such as organ donation and MAID (Yazdani et al. 2018; Gruben and Chandler 2017), the CNS role appears well aligned with priorities to support the development, delivery, and evaluation of MAID services.

7.3.2 Leadership in Research

The Canadian Center for Advanced Practice Nursing Research (CCAPNR) was established in 2011 by CNS and NP faculty to further build capacity to conduct research relevant to advanced practice nursing, both nationally and internationally (Bryant-Lukosius et al. 2017). The faculty built on their experiences as research trainees in a federally funded Chair program that has since closed. While CCAPNR is physically housed at McMaster University, faculty come from six universities in three provinces. The main aims of CCAPNR are to support the optimal integration of CNSs and NPs into health care systems by conducting research, educating and mentoring researchers, and leading knowledge translation initiatives. In the first 5 years of operation, CCAPNR generated over $5.3 million in research funding, published 100 articles, delivered 100 peer review and invited presentations nationally and internationally, and offered a number of innovative research training and learning opportunities for CNSs, NPs, and their stakeholders (Bryant-Lukosius et al. 2017; Harbman et al. 2017). These research and scholarly outputs are significant given that they occur on top of faculty members' independent programs of research and academic requirements in their home universities. In addition, CCAPNR faculty have developed evidence-based guidelines (Bryant-Lukosius et al. 2015) and frameworks and tools (Bryant-Lukosius et al. 2016) to guide meaningful evaluations of CNS and NP roles. Further, CCAPNR faculty have led policy, practice, and research initiatives in at least eight countries. As a result of these initiatives, CCAPNR is recognized as a leader in advanced practice nursing research.

Practical leadership within CCAPNR is provided by two co-chairs, a CNS and an NP from different universities, who bring varied perspectives to inform and guide activities. However, leadership that drives the success of CCAPNR comes from each of its faculty members. In the highly competitive field of research, the faculty *Lead Self* through honest and open interactions within the team to discuss projects and priorities that best suit their interests and career goals. They *Engage Others* by supporting the professional development of their CCAPNR colleagues, graduate students, and novice researchers and providing opportunities for open exchange of

information and collaboration through onsite meetings, webinars, and symposia with stakeholders. They *Achieve Results* by maintaining and communicating a shared vision for CCAPNR and priorities for advanced practice nursing research through regular updates of their terms of reference and by monitoring and reporting on their progress. By establishing trusting relationships with stakeholders, CCAPNR faculty are able to *Develop Coalitions* with interdisciplinary researchers, professional associations, and health care leaders and policy makers to conduct their research and lead research training initiatives. Through their research and knowledge translation activities that challenge the status quo and offer evidence-based solutions, CCAPNR faculty promote *Systems Transformation* to support improved utilization of CNS and NP roles.

7.3.3 Success Factors

From each of the exemplars, the personal characteristics or attributes of the CNS and NP played an important role in their success as leaders. As in the study findings reported by Lamb et al., having a clear vision for their role and how their expertise could be used to improve access and quality of care was evident (Lamb et al. 2016). Ability to recognize and respond to gaps in care delivery for complex, high need, or marginalized populations was also an important factor. Excellent communication and relational skills and ability to establish meaningful partnerships with interprofessional team members and other stakeholders was key to obtaining their support and cooperation in implementing innovative care delivery models.

In a case study of strategies to support optimal NP practice in hospitals, similar leadership attributes and behaviors were observed in three ways (Hurlock-Chorostecki and McCallum 2016). First, to foster cohesive teamwork, NPs built trust in their role competency, respectively negotiated role overlap, facilitated care coordination, and communicated effectively to support shared decision-making. Secondly, NPs provided leadership to evolve the role and advance the specialty by identifying and responding to gaps in care by adapting their role and promoting practice change (Hurlock-Chorostecki and McCallum 2016). Thirdly, NPs fostered the delivery of patient-centered care.

External factors also contributed to successful outcomes for the initiatives led by CNSs and NPs in our exemplars. For example, in relation to the introduction of NPLCs, the provincial NP association in Ontario was becoming quite strong. As a result, the NPs had coalitions in place, developed political insight, and formed meaningful relationships with government policy makers. These assets helped the NPs to best position their proposal for an NPLC and to negotiate their preferred agreement with the government. The use of two frameworks in particular, has also been influential in supporting CNS and NP role enactment for all role domains, including leadership (Kilpatrick et al. 2016; Bryant-Lukosius et al. 2017). The PEPPA framework involves a nine-step participatory, patient-centered process for defining, implementing, and evaluating advanced practice nursing roles. Framework use has been shown to enhance role clarity and strengthen stakeholder

understanding, awareness, and acceptance of CNS and NP roles (Bryant-Lukosius et al. 2017), and thus is a powerful tool for supporting optimal leadership development and implementation. The Canadian Nurses Association has also helped CNSs and NPs clarify and articulate their roles in relation to leadership through the creation of a pan-Canadian framework on advanced practice nursing (Canadian Nurses Association 2019) and NP- and CNS-specific competency frameworks (Canadian Nurses Association 2010, 2014). In addition, policy advisors and the executive team of the Canadian Nurses Association have firsthand knowledge and expertise related to advanced practice nursing and were influential in the drafting of federal legislation for MAID and the prescribing of controlled drugs and substances that leveraged and enhanced the expanded scope of practice for NPs. Targeted national funding for developing PhD prepared nursing faculty (Bryant-Lukosius et al. 2017) and the support of university schools of nursing has been critical for bringing CCAPNR faculty together to conduct the research necessary to inform and evolve the development and use of CNS and NP roles in Canada.

7.4 Challenges and Opportunities

7.4.1 Defining and reporting on CNS and NP leadership

We could have provided many more examples of exemplary CNS and NP leadership for this chapter but were limited by page restrictions. However, most of these examples are anecdotal and from our personal networks of advanced practice nurses and not from published literature, and as a result are not readily accessible to stakeholders who could benefit from more comprehensive understanding of CNS and NP leadership roles. Synthesis and comparison of research findings are also limited by the inconsistent use of definitions and competency domains to describe CNS and NP leadership.

To further our understanding of advanced practice nursing leadership, opportunities exist to develop a common language for defining CNS and NP leadership. Studies have shown that Canadian health care providers, administrators, and policy makers impact on leadership role enactment (Kilpatrick et al. 2016; DiCenso et al. 2010) but do not always have a good understanding of CNS and NP leadership and may not even have expectations that this is an essential part of their role (Bryant-Lukosius et al. 2010; Martin-Misener et al. 2014). CNSs and NPs also comment that their leadership activities can constitute invisible work and that the important impacts of this work are often not recognized by health care team members and administrators (Hurlock-Chorostecki and McCallum 2016; Bryant-Lukosius et al. 2010). A standardized definition is necessary to communicate effectively to stakeholders about the pivotal nature of CNS and NP leadership and to develop psychometrically sound instruments to measure and evaluate the outcomes of this work.

The capabilities outlined in the LEADS framework provide important insight into how CNS and NP leadership can be defined. A benefit of using the LEADS framework is that it is widely accepted in Canada by health care administrators and

policy makers who are frequently involved in making decisions about the funding, hiring, supervision, and role enactment of CNSs and NPs (Waddell et al. 2019). In addition, a rapid review of the literature indicates that the capabilities outlined in LEADs framework are well aligned to support emerging leaders to effectively respond to drivers for change that will transform the future of health care (Waddell et al. 2019). Thus, application of the LEADS framework may help to better communicate the leadership work of CNSs and NPs in a language understood and valued by key stakeholders, and also prepare CNSs and NPs for the future leadership challenges they will encounter in the health care system.

In a previous national study, stakeholders noted that CNSs were not as involved as NPs in advocating for their role and also articulating how their knowledge, skills, and expertise could be used effectively to address strategic priorities for improving care delivery (Bryant-Lukosius et al. 2010). The experience of CNSs in establishing the ACGNN and the leadership attributes they employed in relation to the LEADS framework may provide a template for raising the profile of other CNSs in Canada.

The need for CNSs and NPs to be transformative leaders has never been greater, given the complex and dynamic nature of health care systems and the technological, environmental, economic, and social issues that are challenging the sustainability and very nature of how health care services can be provided (Health Leadership Academy 2019; Bryant-Lukosius et al. 2018b). The need to strengthen CNS and NP curricula to develop role-ready leadership skills to address these health care system challenges has been reported (Health Leadership Academy 2019). Integration of the LEADS framework into graduate nursing program curricula may be one strategy to strengthen the leadership components of these roles.

Ongoing mentorship and support are also required to further develop CNS and NP leadership skills following graduation. An important observation is that all three exemplars illustrated leadership provided by very seasoned CNSs and NPs with lengthy work experience in their roles. As a growing number of very experienced CNSs and NPs retire in Canada, they are being replaced by novice nurses who do not feel confident in all aspects of their roles, including leadership (Doerksen 2010; Gehrs et al. 2017). Declining numbers of CNSs in Canada has also led to difficulties in recruiting experienced CNSs in some specialty areas (Gehrs et al. 2016). Increasingly, health care organizations are recognizing that they need to play a strong role in providing learning opportunities and mentorship to develop the competence and confidence of novice CNSs and NPs. One such example is an innovative mentorship program established by the Center for Addiction and Mental Health (CAMH) to provide professional development and mentorship for novice CNSs (Gehrs et al. 2016). Unable to recruit a sufficient number of CNSs with mental health expertise, CAMH received innovative funding from a charitable foundation to launch a competency-based mentorship program to develop CNSs. Integral to the program was to develop CNS competencies as a leader. The program offers a 6-month paid internship to develop mental health nursing knowledge and skills and to gain confidence as a clinical leader (Gehrs et al. 2016). In addition, the CNSs lead the development of their individualized role development plan and receive mentorship from a network of clinical leaders who act as role models. The CNSs gain

experience in leading quality improvement and evidence-based practice initiatives, managing complex clinical problems, and completing scholarly papers and presentations. The program has been effective in recruiting and growing their own CNSs and expanded to include NPs and other clinical leaders (Gehrs et al. 2016, 2017).

7.5 Conclusion

In summary, leadership is an essential component of CNS and NP practice in Canada. However, how CNS and NP leadership is defined and understood by key health care system stakeholders is variable. Further efforts are needed to establish a common language to define advanced practice nursing leadership, conduct research, and to report on the impact of CNS and NP leadership for patients and families, health care providers, organizations, and health systems. The capabilities outlined by the LEADS framework are very relevant to advanced practice nursing roles. Application of the LEADS framework to define advanced practice nursing leadership and develop tools to measure leadership may inform the future evolution of CNS and NP leadership. The LEADS framework may also provide a solid foundation for enhancing graduate program curricula and supporting the ongoing leadership development of CNSs and NPs.

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Advanced Practice Nursing in the Eastern Mediterranean Region

8

Fariba Al-Darazi and Majid Al-Maqbali

8.1 Introduction

This chapter describes the development of advanced practice nursing in the Eastern Mediterranean Region and delineates success stories and the challenges facing the nursing leadership in this regards. The chapter is based on a desk review of the reports on advanced practice nursing in the region, World Health Organization Regional technical papers and resolutions and responses were received from selected nursing leaders in the region to a questionnaire on advanced practice nursing and nurse prescribing.

8.2 Regional Context

The Eastern Mediterranean Region (EMR) of the World Health Organization (WHO) is comprised of 21 Member States and the Occupied Palestinian Territory (West Bank and Gaza Strip). It has a population of nearly 620 million people. Except for Afghanistan, Iran and Pakistan, all are Arabic speaking. Long standing political instability, conflicts and civil unrest are features of this region. Inequities in health, rising exposure to health risks, increasing health care costs and unacceptably low levels of access to quality health care represent the most important challenges facing

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many countries of the Region (World Health Organization-Eastern Mediterranean Regional Office 2012).

Recent events have added to regional instability and the significant conflicts taking place in some countries has resulted in the displacement of large numbers of the population, the exodus of a large percentage of the health workforce, disruption of supply systems, destruction and neglect of health infrastructure and the inevitable disruption to health services.

The Eastern Mediterranean Region suffers from the health problems similar to the rest of the world. Non-communicable diseases are the leading killers in the Region, while communicable diseases and nutritional disorders remain considerable and preventable deaths from injuries constitute a serious proportion of overall mortality (World Health Organization-Eastern Mediterranean Regional Office 2015a).

Nurses and midwives constitute 50–60% of the health workforce in the Region demonstrating the potential resources of the nursing profession.

8.3 Development of Advanced Practice Nursing: Early Years

In 1990, the Regional Advisory Panel on Nursing was formed by WHO. Since its establishment, the Panel has provided a regular mechanism for nurse leaders in the region to identify needs and priorities requiring action by the organization and to discuss issues and plans of action that could be positively affected by regional office support to strengthen nursing and midwifery in the region.

In 1998, resolution EM/RC45/R.12 on improving quality of nursing and midwifery in the Eastern Mediterranean Region was adopted by the Forty-fifth Session of the Regional Committee of the WHO. The Regional committee is the governing body of WHO in the Region and consists of Ministers of Health in the 22 Member States. During this meeting, the regional strategy for nursing and midwifery development and the educational standards for nursing specialization were set at the regional level as a result of advice and efforts of the Regional Advisory Panel on Nursing and adopted. The Eastern Mediterranean Region was the first region among the six regions of WHO to develop such a strategy (World Health Organization-Eastern Mediterranean Regional Office 1997, 1998a, b).

The countries of the region continue to invest in the development of nursing and midwifery resources as a critical component of the health system and health services development.

Since the first meeting of the Regional Advisory Panel on Nursing in 1990, tremendous progress has been achieved in nursing and midwifery development, both at the national and regional levels. The nursing leadership played a pivotal role in the development of nursing across all fields including advanced practice nursing; this was augmented by the technical support provided by the World Health Organization to the countries of the region. Several strategies were adopted to strengthen nursing including reforming basic nursing education and developing graduate programs,

strengthening nursing structures in ministries of health and leadership development, strengthening nursing and midwifery regulation, establishing national strategic plans for nursing and midwifery development, and supporting countries in complex emergencies and conflict to build and rehabilitate their nursing and midwifery services. Nursing in the region, witnessed a growth in entry level BSN nursing programs, an increase in the number of nurses prepared at the graduate level and an increase in the number of nurses in leadership positions.

As a response to the challenge of providing timely and accessible service to clients, especially the more vulnerable members of the community in the region, the World Health Organization held the fifth meeting of the Regional Advisory Panel on nursing in June 2001 in Pakistan. The meeting and the consultation on advanced practice nursing and nurse prescribing in the Eastern Mediterranean Region discussed the scope of professional roles and responsibilities, regulation of advanced practice nursing and implications for nursing education and practice. This meeting was organized by the World Health Organization Regional Office for the Eastern Mediterranean Region. Chief nurses, deans of schools of nursing, presidents of national nursing organizations, regional and international nursing experts and a number of physicians and pharmacists participated in the three-day meeting.

The consultation led to a consensus on the following recommendations:

1. Member States should review the current practices in relation to advanced nursing practice and invest in systematic data collection and dissemination of information regarding cost-effective, best practices.
2. Member States should develop and strengthen educational programmes to prepare advanced practice nurses at all levels of health care (primary, secondary and tertiary) consistent with the regional educational standards for nursing specialization.
3. Member States should develop and strengthen legislation and the nursing regulatory framework that supports advanced practice nursing within the overall health system.
4. Member States should create a career structure for advanced practice nursing within health systems in the Region.
5. WHO should provide guidelines to assist countries in the process of developing and strengthening advanced practice nursing at all levels of health care.
6. WHO should assist Member States in their efforts to develop and strengthen advanced practice nursing (World Health Organization-Eastern Mediterranean Regional Office 2002).

This meeting created an opportunity for discussing advanced practice nursing in different countries and was the first milestone in the development of advanced practice nursing in the region. Over the years, the World Health Organization and the nursing leaders in the region advocated for advanced practice nursing. Historically, nurses in the region have been recognized as key practitioners in community and public health. The progress has been slow but steady.

The second milestone was the Regional committee resolution adopted in October 2008 EM/RC55/R.5 on promoting nursing and midwifery development in the Eastern Mediterranean Region, which called for advocating for new and specialized roles. It called for establishing family health nursing, including the educational programmes and service delivery structures to support the role and development of advanced practice nursing at the primary, secondary and tertiary levels of care (World Health Organization-Eastern Mediterranean Region 2008).

8.4 Development of Advanced Practice Nursing: Recent Developments

The contribution of nurses to the health outcomes of populations and to a well-functioning health system is crucial for any country. In order to identify the challenges facing nursing in the countries of the region, 'In late 2014, the Regional Office undertook the Eastern Mediterranean Nursing and Midwifery Survey as well as a desk review of WHO reports on missions to countries of the Region in the previous four years and data from the nursing country profiles provided by key informants from Member States. The overall aim was to assess the current status of nursing and midwifery in the EMR and to identify the key challenges facing these services. The survey was delivered as an online questionnaire and 20 of the 22 EMR member countries responded' (Raising the profile 2015).

As a follow up to these activities, a report was produced and a regional forum, entitled future of nursing and midwifery in the Eastern Mediterranean region, was held in Amman-Jordan in April 2015. Nurse leaders from the region and regional and international experts participated in the meeting, discussed the challenges facing nursing in the region and proposed actions to address the challenges (World Health Organization-Eastern Mediterranean Regional Office 2015b, c).

Although half of the countries surveyed stated that nurses practiced at the advanced level in their country, the description of what these roles actually entailed indicates that there is quite a varied understanding of the nature and scope of advanced practice. For some it meant nurses working in a specialist or supervisory role or carrying one or two 'advanced' tasks (e.g. prescribing, suturing, venepuncture), some of which are seen as advanced in some countries but are part of the general nurse's repertoire of skills in others.

International consensus has established that the advanced role includes the capacity to integrate research, education and clinical management, a high degree of autonomy and independent practice, advanced assessment and decision-making skills, and recognized advanced clinical competencies (Schober and Affara 2006).

Based on the survey results and the situation analysis of nursing in the region in 2015, the regional framework for action for strengthening nursing and midwifery in the EMR was developed to address the five main challenging areas facing nursing

and midwifery including governance and regulation; workforce management systems; practice and services; access to quality education and research.

Results from the online Eastern Mediterranean nursing and midwifery survey identified key challenges for nursing and midwifery in the region. With regards to the domain of practice and services, most of the countries believe that there is potential for the development of the advanced practice role especially within primary health care and the management and control of non-communicable diseases. However, constraints to the evolution of this role are considerable, including low governmental and organizational support, confused public perception, role ambiguities, a scarcity of well-educated nurses experienced in the role, physician domination and opposition, and a lack of resources.

The framework entitled, 'Strengthening nursing and midwifery in the Eastern Mediterranean Region: A framework for action 2016-2025' was published in 2016. The regional framework serves as a roadmap to guide Member States in transforming nursing and midwifery in the Region with short-term and medium-term actions.

The strategic direction under the domain of practice and services in the regional framework states that nurses and midwives should practice to the full extent of their education and experience to deliver quality care. Short-term and medium-term actions aimed at introducing expanded or advanced practice role in nursing have been identified and form a basis for further development of advanced practice nursing in the region (World Health Organization-Eastern Mediterranean Regional Office 2016).

To provide guidance to the countries in the region on advanced practice nursing and nursing specialization, a framework for the development of nursing specialties and advanced practice was developed as an outcome of the regional consultation on nursing education in 2013 (World Health Organization-Eastern Mediterranean Regional Office 2013). Participants included selected deans of nursing, experts in nursing education, selected members of the Regional Advisory Panel on Nursing, the Chairperson of the Global Advisory Group on Nursing and Midwifery, representatives of the WHO collaborating centres for nursing in the Region, a representative of the Scientific Society of Arab Faculties of Nursing, as well as WHO staff from headquarters and regional (African and Eastern Mediterranean) levels. Consensus was reached on what is considered as a nursing specialty, the definition of a nurse specialist, criteria for designating a speciality and levels of nursing specialist practice; description of the level of practice; proposed professional titles; educational requirements and the regulatory mechanism.

The guide, published in 2018, was used to foster development of advanced practice nursing in the region (World Health Organization-Regional Office for the Eastern Mediterranean 2018). The following figure illustrates the level of specialist practice, which was adopted by the region (Daly and Carnwell 2003) (Fig. 8.1).

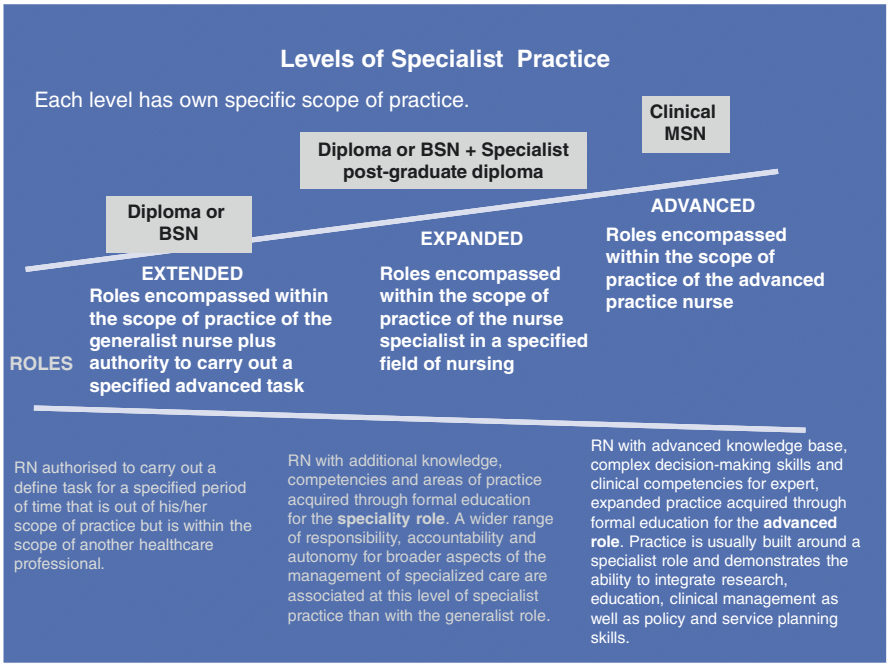

Fig. 8.1 Continuum of the levels of nursing specialist practice. (Adapted from Daly and Carnwell 2003)

8.5 Current Status

To obtain further information about the recent developments related to advanced practice nursing, a questionnaire was sent to a selected group of nurse leaders in 11 countries of the region (Annex 1). The questions addressed nurse prescribing and advanced practice nursing.

8.5.1 Educational Preparation, Definition, Scope of Practice and Practice Settings

Table 8.1 illustrates the status of advanced practice nursing in the region. With regards to the educational preparation for the APN role, six of the countries responded that a master of science in nursing with a clinical focus has been identified as an educational requirement for the role and the remaining countries had not defined the educational preparation. Only three countries had an approved definition of APN while four had a written definition which has not been approved yet. Three countries did not have a definition of advanced practice nursing. Only four countries had a written and approved scope of practice for the role (Iran, Jordan, Oman

Table 8.1 Status of advanced practice nursing in the Eastern Mediterranean Region

Country	Educational preparation	Written and approved definition of advanced practice nursing	Written and approved scope of practice	Core competencies identified
Bahrain	MSc in nursing[a]	Written but not approved yet	No	No
Egypt	Not defined	No	No	No
Iran	MSc in nursing[a]	Yes	Yes	Yes
Jordan	MSc in nursing[a]	No	Yes	Yes
Lebanon	MSc in nursing[a]	Written but not approved yet	Written but not approved yet	Yes
Oman	MSc in nursing[a]	Yes	Yes	Yes
Pakistan	Not defined	Written but not approved yet	No	No
Qatar	MSc in nursing[a]	Yes	Yes	Yes
Tunisia	Not defined	No	No	No
United Arab Emirates (UAE)	Not defined	Written but not approved yet	Written but not approved yet	No

[a]With a clinical focus

and Qatar). Lebanon and the UAE have a written scope of practice, which has not been approved yet. Five countries have identified the core competencies for the role including Iran, Jordan, Lebanon, Oman and Qatar.

Most of the countries indicated that advanced practice nurses practice in a wide variety of settings such as hospitals, primary health care centres and community settings in different specialty areas such as paediatrics, midwifery, gerontology, mental health, emergency care, family health and public health.

8.5.2 Regulation of APN and Nurse Prescribing

Only in two countries, Jordan and Qatar, the APN role is regulated; Iran and Oman are in the process of establishing the process for regulating the role.

With regards to nurse prescribing, nurses do not prescribe medicines in all the countries that responded to the questionnaire except Oman whereby primary health care nurses prescribe a list of 22 drugs in primary health care settings. So far, the system is not ready to allow APNs to prescribe except under the approval of the consultant physician. Whereas midwives can prescribe a list of drugs that have been pre-authorized and the prescription is regulated in Tunisia, Qatar, Iran and Pakistan. In Pakistan, lady health visitors are the primary community health workers who have completed 53 weeks of training and who work in rural community services taking care of the healthy and sick individuals and families. The lady health workers

can prescribe a predefined list of drugs; also in Iran, the community health workers (Behvarz) can prescribe a predefined list of drugs. In the UAE, what nurses can prescribe will be defined and will be part of a collaborative agreement for each practitioner within the institution. In Iran, Qatar Tunisia and Oman, the Ministry of Health grants the legal authority for prescribing to the categories mentioned previously.

The drugs prescribed by midwives, lady health visitors and community health workers range from vitamins to ante-natal vaccinations, contraceptive methods and drugs for treating minor childhood illnesses. Midwives in Tunisia also prescribe some obstetrical medicines.

In Iran, nurses can refer patients from home health care settings to health care professionals or health facilities. Also, in Qatar and Pakistan nurses can refer patients to physicians. Whereas in Oman PHC nurses refer patients to the secondary level of care and in other specialties, APNs refer patients to consultant physicians e.g. emergency.

In a few countries, the standard protocols for specified cases are set within the institutions, thus allowing nurses and midwives to prescribe especially in emergency cases and in the absence of physicians (Bahrain, Oman, Qatar, Tunisia and the UAE).

8.6 Development of Advanced Practice Nursing in Oman: A Case Study

In this section, the journey of the Sultanate of Oman as one of the first leading countries that has systemically developed the APN role in the Eastern Mediterranean Region will be described.

In Oman, the fifth meeting of the Regional Advisory Panel on Nursing in 2001 provided the impetus for advocacy and discussion of the advanced practice nursing role and its significance in ensuring access of the population to health care. Nurse leaders from Oman, who participated in the meeting, were able to discuss the challenges faced by them with nursing colleagues from the other Eastern Mediterranean countries and with international nursing experts in the field.

Health policy makers in Oman sought WHO's technical support to assess the status of primary health care, community needs and the potential for developing the advanced practice nursing role in the country. The journey started with a situational analysis of the national status, site visits by experts and a presentation to the senior policy makers about the relevance of the implementation of advanced practice nursing in Oman. The journey started in 2004 after an in-depth assessment of primary health care in the country. One of the strategic objectives for primary health care in Oman was to expand the role of nurses in care delivery by developing advanced practice nurses. The argument for establishing the role was clearly stated in the PHC assessment report, "the need to develop a more cost-efficient mode of PHC delivery which could be deployed to move PHC provision closer to the community".

The experience of other countries in this field point to advanced nursing practice as a successful, affordable and reliable mode of PHC provision. The unrecognized independent practice of nurses takes place without adequate technical support and

leaves the nurse legally unprotected' (Abdel Rahim Ebrahim 2004). The assessment report recommended initiation of the advanced practice nursing role in primary health care as a priority for introducing the APN role.

The APN development journey in Oman included review of the literature about APN, workshops, focus group meetings and a consultation process with a multidisciplinary group of health professionals to discuss advanced practice nursing and the justification and feasibility for introducing the role within the health system in the country. The multidisciplinary team included primary health care nurses, educators, senior managers, physicians, pharmacists and regulators. Also WHO supported several missions to the country (Ghebreiwet 2005; Schober et al. 2012).

By 2012, the outcome of the expanded assessment and the situational analysis of APN and a way forward were presented to the policy makers and key stakeholders in the country. As a result, a resolution was issued by the relevant section within the Ministry of Health to study the steps for the implementation of the APN role in hospitals. The national taskforce, which was formed in 2013 based on the ministerial resolution, proposed the scope of practice, educational requirements, service delivery structures, criteria for selection of nurses for the role, career structure, and inclusion of the category within the workforce plan.

Evidence of why the role should be initiated to PHC and educational opportunities for nurses to be trained for this role in Oman and in the International level was shared with the decision-makers in the Ministry of Health. As no educational program for preparing nurses for the role was available in Oman, visits to various universities outside the country were made to familiarize with APN programs in 2014.

In 2016, a WHO consultant worked with the national taskforce to guide the integration of the APN role within the existing primary health care setting in Oman. By this phase, the legal framework for practice, job description, standards of practice, required competencies, practice environments and service delivery structure required for the implementation of the role had been developed. On the job training programs for nurses practicing the advanced practice role in PHC were developed by the taskforce.

Seven nurses were sent on scholarships outside the country to be prepared for the APN role by obtaining a master of nursing in a specialty field, they returned and are currently attached to various facilities. Many of these nurses went on to become leaders.

A comparative situational analysis of nurses practicing APN roles beyond their scope of practice in primary health care settings between 2010 and 2016 revealed that the number of nurses practicing advanced nursing roles in primary health care institutions has increased from 19% in 2010 to 35% in 2016 (Al Maqbali 2018). Nationally, the role is practiced in 60% of the primary health care institutions.

In summary, the results of this comparative situational analysis suggest that nurses need to be provided with appropriate educational preparation and advanced skills in order to function in this advanced practice role. Legitimizing the role with adequate training and supervision will surely serve as an innovative way of ensuring quality of care, system efficiency and cost effectiveness. This process paves the way forward to go ahead with the proposed plan of action.

The case study from Oman, illustrates that Oman is prepared to proceed with the inclusion of the APN role in health care facilities especially in the PHC setting. Once the ANP role is implemented, the other countries in the Eastern Mediterranean Region can look to Oman to provide a model that can be replicated elsewhere.

8.7 Conclusion

The progress of advanced practice nursing in the region has been slow but steady. A lot of advocacy and role clarification has taken place among nurses, health professionals and health policy makers within the region. Advanced practice nursing deserves particular attention. Recently, the region has shown interest in developing the family health nursing role with an MSc in nursing, where these nurses can perform their roles in collaboration with family physicians and contribute to better health outcomes. The push for family health nursing in the Region includes changing health care systems, epidemiological and demographic changes, an increased focus on primary health care, rising demand for specialization, the growing need for home care and escalating health costs (World Health Organization-Eastern Mediterranean Regional Office 2013).

Political commitment and nursing leadership is required to move forward with the agenda on nursing specialization in the Region. Currently, policy makers have made a clear commitment to this process. However, educational preparation, legal framework and necessary administrative support need to be examined. Priorities for nursing specialization and advanced practice nursing in the Region are mental health nursing, community/public health and family health nursing, midwifery, critical care nursing, oncology nursing and gerontological nursing.

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ANNEX 1: Advanced Practice Nursing (APN) in the Eastern Mediterranean Region Countries[1]

I am working on updating the situation of advanced practice nursing and midwifery in our region, I would greatly appreciate it, if you take a few minutes to reflect on

[1] Adapted from the Report on the Fifth Meeting of the Regional Advisory Panel on Nursing and Consultation on Advanced Practice Nursing and Nurse Prescribing: Implications for Regulation, Nursing Education and Practice. Islamabad, Pakistan, 24–26 June 2001. World Health Organization-Eastern Mediterranean Regional Office. Cairo, Egypt, 2002.

the following questions and provide answers to the best of your knowledge about the situation in your country:

1. What is the educational preparation for advanced practice nurses in your country?
2. Is there an agreed upon definition for APN in your country?
3. Is there a written scope of practice for APN?
4. Is the APN regulated in your country?
5. What are the core competencies identified for the role?
6. What are the various practice settings in which the nurse can exhibit the role?
7. Describe the nature of nurse prescribing in your country:
   (a) Do nurses, midwives, public health/community health nurses, lady health visitors, other support workers to nursing (community health workers, lady health workers) prescribe?
   (b) If yes, is there a legal framework for nurse prescribing in your country?
   (c) Who grants nurses, midwives and other nursing personnel this authority?
   (d) Describe the regulatory process for nurse prescribing and under what circumstances?
8. What can nurses, midwives and other support workers to nursing prescribe and under what circumstances?
9. Do nurses prescribing have the right to refer patients to other professionals?
10. Are there cases where protocols, standards are set which allow nurses, midwives and other support workers to nursing to prescribe?

Thank you for your participation

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Advanced Practice Nursing in Hong Kong and Mainland China

9

Frances Kam Yuet Wong and Arkers Kwan Ching Wong

Two roads diverged in a wood, and I took the one less traveled by, And that has made all the difference. (Robert Frost)

Frances Kam Yuet Wong and Arkers Kwan Ching Wong

9.1 Prologue

This chapter is a documentary of how nurses in mainland China and Hong Kong strive for excellence in the development of nursing. The incremental success in reaching the higher goals takes work of multiple key players and opportunities available at the time, with sustained efforts bringing the work forward to the next stage. In the process, the ingredients of the *right time*, *right person* and *right moments* are all important. The leaders emerged in these opportune moments are catalysts to bring about the success. The first author, FW, is privileged to be involved deeply in the development of advanced nursing practice in Hong Kong and mainland China particularly in the Greater Bay Area. Together with her, there are many leaders in the field that contribute greatly, including leaders in the hospital services, public health, universities and government policy. FW was involved in a number of strategic works related to advanced nursing practice such as the pioneering of nurse clinics, the establishment of the Hong Kong Academy of Nursing and the alliance of key partners in Mainland China. All these developments can only be accomplished with a mission shared by visionary individuals

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who work in alliance supported by policy at the opportune time. Here below begins the story of development of advanced nursing practice in mainland China and Hong Kong.

9.2 Background

Nurses are called to respond to societal needs in promoting the health and well-being of the people they serve. Nurses at the entry level of the profession possess the competence to function as Registered Nurses, essentially as generalists. The novice nurse will soon realize that the basic pre-registration education is not adequate to deal with day-to-day clinical practice. The advancement of medical and healthcare sciences demands that nurses today expand and extend the role to assume more responsibilities in healthcare. Progressing through the levels of practice from novice to expert, the nurse will develop more advanced competencies in solving complex clinical situations. The common term for describing this level of nursing competence is advanced nursing practice, denoting practice beyond the basic level. The umbrella term of advanced practice nurse (APN) is used to refer to the registered nurses who possess an expert knowledge base, complex decision-making skills and clinical competencies (International Council of Nurses 2009). In fact, these APNs play a key role in the nursing and healthcare professional team, contributing to client care, healthcare delivery services and professional development (Wong 2018a). They act as clinical leaders in the specific specialty area they represent, bringing about positive client outcomes and innovative approaches to care delivery that enhance accessibility, efficiency and effectiveness (Wong and Chung 2006; Wong 2018b).

Advanced nursing practice is developing around the world, but the stage of development varies from country to country. Approximately 70% of hospitals around the world have some form of advanced practice nursing (Parker and Hill 2017). Hong Kong and mainland China, like the other parts of the world, face a similar need for service that is driven by medical and healthcare advancement supported by technology and new evidence in managing complex client cases. These require nurses to be better equipped with the necessary competence to deal with complicated situations. The experience of the authors is that the successful introduction of APNs requires at least three interrelated factors: need for service, APN education and competence, and system and policy support.

This chapter will use Hong Kong and mainland China (Guangzhou) as a case study to illustrate how advanced nursing practice has developed with the interplay of the above three factors over the last two decades. China is a vast country, and the development of APN can vary greatly across provinces and cities, depending on local contextual situations such as resources, education level, management support and the like. This chapter will focus on the city of Guangzhou, which is near Hong Kong and has similar demographic and economic conditions. Guangdong province has used its geographical advantage to

Table 9.1 Key events related to APN development in Hong Kong and Guangzhou

	Hong Kong	Guangzhou
Need for service	1990—Hospital Authority established to improve efficiency and retain qualified staff 1993—Clinical nurse specialists introduced to provide specialty care 2000—Nurse clinics set up to enhance continuity and accessibility of care 2009—Nurse consultants introduced to address complex population health needs	(At the national level) 2005—The Chinese Nursing Career Development Plan (2005–2010) first mentioned the need to develop specialty nursing in China 2012—The 2011–2015 Strategic Plan mentioned specific service areas needed for specialty nurses 2016—The 13th Five-Year Plan reiterated the need to educate a critical mass of clinical specialists for quality services
Education and competence	1995—Hospital Authority School of Post-basic Nursing Studies established (subsequently named as The Institute of Advanced Nursing Studies) 1995—First master's degree program in nursing launched 2002—The Hong Kong Academy of Nursing (HKAN) Preparatory Committee launched 2012—14 Specialty Colleges established under the umbrella of The HKAN with a defined competency framework, accreditation and certification system, admitting Members and Fellows demonstrating practice at an advanced level	2001—One of the earlier specialty nursing training programs offered in Beijing 2004—Hong Kong and Guangzhou introduced the first postgraduate specialty training course 2007—Guangdong Ministry of Health sent 614 nurses to be trained in 14 different specialties by the Hong Kong Hospital Authority 2011—Nursing upgraded to a first-level discipline and clinical master's programs launched in the country
System and policy support	2017—The Food and Health Bureau of the Hong Kong Government issued a 'Strategic Review on Healthcare Manpower Planning and Professional Development', acknowledging the importance of specialized advanced nursing practice 2018—A work group on Advanced/Specialized Practice set up under The Nursing Council of Hong Kong by instruction of the Hong Kong government, to define APN competencies and training standards and a mechanism for registry	2017—Formation of the Greater Bay Area by the Chinese government to drive business and the economy in the area 2018—First APN Certification Assessment exercise under the Greater Bay Area Scheme

engage in close networking with Hong Kong in the development of specialty nursing and APNs.

There are three essential areas that facilitate the introduction of APNs: 'need for service', 'education and competence', and 'system and policy support'. The key events of these areas happened in Hong Kong and Guangzhou will be depicted below and Table 9.1 provides a synopsis of the occurrences.

9.2.1 Need for Service

In Hong Kong, the public health system funded by the government has shouldered the major healthcare demands of citizens, especially in hospital care (Lai et al. 2018). At the end of 1980s, healthcare reform measures resulted in the establishment of an independent Hospital Authority. The provisional Hospital Authority was tasked with devising mechanisms to optimize the use of available resources, improve efficiency, and attract, retain and motivate qualified staff (Wong 1998). One of the key changes in the reform related to nursing was the development of both managerial and clinical career pathways. The managerial pathway was clear, with the post of ward manager and department operations manager established in every ward and department. The clinical pathway was less structured and well defined. There is a rank above the staff nurse, which is the clinical nurse specialist (CNS). However, at first only 22 CNSs had appointments in 14 clinical areas in 1993 (Wong 2001). The establishment of CNS positions is dependent on the available resources. CNSs, equipped with expertise in the related area of practice, have built collaborative relationships with other members of the healthcare team and provided quality care that meets service needs (Wong 1998). They have proven to be valuable members of the healthcare team, contributing to total patient care.

An example of the work of these APNs is the introduction of nurse clinics. Nurse clinics were introduced in Hong Kong in 2000 with the aim of enhancing continuity of care and access to care, and to contain costs (Wong and Chung 2006). The clinics provide opportunities for patients to receive early intervention using non-pharmaceutical nursing therapeutics and timely review of their clinical condition in-between medical consultations. The optimal maintenance of clients' health by providing education, counselling and case management helps to maintain clients in the community as long as possible without the need for inpatient service. A research study conducted at the time when the nurse clinics were launched has shown that they were able to improve client symptoms, prevent complications and enhance patient satisfaction (Wong and Chung 2006). Based on this evidence, a set of guidelines on the accreditation of Hospital Authority Nurse Clinics was established to guide the corporate quality assurance.

In order to make further use of advanced nurses on the clinical front and thereby improve quality of client care and health outcomes, the position of Nurse Consultant was introduced in Hong Kong in 2009. Nurse Consultants have been proven to be able to address complex population health needs and assume a clinical leadership role in shaping guidelines and policy in collaboration with an interprofessional team at the system level (Wong et al. 2017). The Nurse Consultants, share similar features of CNS clinically, but function at the highest level of practice where they have the responsibility and access to policy making level to effect change. They analyze and manage complex care delivery processes, develop and improve services.

In mainland China, the need to develop specialty nursing was first mentioned in the Chinese Nursing Career Development Plan (2005–2010) (Ministry of Health of the People's Republic of China 2005). In the subsequent 5-year plans, the need to develop specialty nurses was reiterated and more directive details were provided.

The 2011–2015 strategic plan specified that a total of 25,000 specialty nurses should be developed in the areas of critical care, emergency, blood purification, oncology and operation room nursing (Ministry of Health of the People's Republic of China 2012). The current 13th Five-Year Plan emphasizes the need to educate a critical mass of clinical specialists to enhance the standards of the overall nursing team in meeting the multiple levels of people's healthcare needs, extending from the hospital to the community (Gazette of the National Health and Family Planning Commission of People's Republic of China 2016). Patients with high needs, particularly in the community, are those with chronic illness, rehabilitation needs and long-term conditions, the elderly, and those requiring palliative care.

9.2.2 Education and Competence

In Hong Kong, the education of specialty nurses was started in the Hospital Authority with the establishment of the School of Post-basic Nursing Studies in 1995. Before this time, nurses requiring specialty preparation were sent overseas for training. The School has now been renamed as The Institute of Advanced Nursing Studies and integrated into the Hospital Authority Institute of Health Care. It continues to provide Specialty Nursing Certificate Courses to nurses who work in the Hospital Authority. While the Institute offers quite structured in-service type courses to equip nurses with knowledge and skills in a variety of specialty areas, the nursing profession in general feels the need to deepen and broaden education programs, going beyond training to meet immediate service needs. With this mission, the Hong Kong Academy of Nursing (HKAN) was set up to position advanced nursing practice in Hong Kong to be on par with the international standards.

The exploration of the establishment of the HKAN commenced in 2002 with the setting up of a working group in the Nursing Council of Hong Kong. The government agreed in principle and delegated the work to an HKAN Preparatory Committee. Between 2009 and 2011, with the support of a Fulbright Scholar Consultant and other overseas experts, as well as tremendous efforts among the local specialists, a set of generic competencies for advanced nursing practice was formulated. During the discourse, there was much discussion on the categories of specialization. The committee adopted the principle that the categories would remain broad so as to gather a critical mass of nurses in a defined specialty area but allow sub-specialization within the larger category. Another consideration was that the categories needed to be in alignment with the classification of healthcare services in order to facilitate readiness of application of expertise in service. In 2012, 14 specialty colleges were established under the umbrella of the HKAN: the Colleges of Cardiac Nursing, Community and Public Health Nursing, Gerontology Nursing, Critical Care Nursing, Education and Research in Nursing, Emergency Nursing, Medical Nursing, Mental Health Nursing, Midwives, Nursing and Health Care Management, Orthopedic Nursing, Perioperative Nursing, and Surgical Nursing. Today, there is a system in place within the HKAN to accredit the specialty colleges to endorse their specialty competencies, theoretical curricula, clinical

logbooks and examinations. The HKAN works closely with the universities and clinical settings to facilitate the education of younger nurses and enable them to fulfill the education requirements. Nurses who have met the curriculum requirements and passed the examination are granted membership and fellowship of the HKAN with a designated specialty. Details are available at www.hkan.hk.

The first master's degree program in nursing commenced in 1995 at the Hong Kong Polytechnic University. The other two publicly funded universities, The Chinese University of Hong Kong and The University of Hong Kong, also now offer master's programs in nursing with a clinical focus. These universities work closely with the HKAN to align their curricula to partially meet the requirements of the HKAN and the specialty colleges. There are also interdisciplinary programs in collaboration with the Faculty of Medicine in the local universities, which provide focused clinical programs to equip nurses with advanced competencies.

In mainland China, one of the earliest specialty nursing training programs was introduced in 2001, when the Chinese Nurses Association invited Hong Kong to deliver an ICU course in Beijing. Guangzhou took advantage of its geographical proximity to Hong Kong and commenced the first specialty training course at postgraduate level in 2004. The Hong Kong Polytechnic University provided a consultancy course for Nanfang Medical University, concentrating on four specialty areas: intensive care, infection control, geriatrics and diabetes care (Wong et al. 2010). Upon completion of the consultancy course, students can proceed to complete the master's program at Nanfang Medical University. In 2007, the Guangdong Ministry of Health made a contractual agreement with the Hong Kong Hospital Authority to prepare 614 APNs from 150 hospitals in 14 different specialties over 4 years (Liao 2011).

Nursing in mainland China has conventionally been positioned as a discipline under medicine. In 2011, nursing was upgraded to a first-level discipline, which means that the discipline of nursing has the autonomy to define its own curriculum and education. Since then, education at the postgraduate level has developed very rapidly. Clinical master's programs with the aim of preparing nurses to practice at an advanced level are mushrooming. There are now at least 85 clinical master's programs across the country, with the universities working closely with their clinical partners to design curricula to meet service needs. A program in Beijing has begun to educate a small number of nurse practitioners (Wong 2018a).

9.2.3 System and Policy Support

The development of advanced nursing practice in Hong Kong was mainly driven by service needs. System and policy support are needed to set standards that are applicable across various settings, with well-defined education requirements and clinical competencies to protect both the public and the profession. The HKAN mentioned above is the main professional association striving for statutory status for APNs and for title protection in Hong Kong. The Hong Kong government in principle agreed with the direction and assigned the work to an HKAN Preparatory Committee, as

described above. The committee then evolved into the HKAN, which was officially set up in 2012. In 2017, the Food and Health Bureau of the Hong Kong government issued a 'Strategic Review on Healthcare Manpower Planning and Professional Development', which acknowledged that specialization in nursing is instrumental in helping to revitalize healthcare systems. In 2018, the Hong Kong government instructed the Nursing Council of Hong Kong to set up a work group to formulate the scope of practice and core competencies, devise a mechanism to recognize training institutes, and set up an advanced/specialized practice register under the Nursing Council. In light of the outcome of the pilot scheme, the government is considering devising a statutory registration scheme in the long run. Over the years, the HKAN has lobbied different stakeholders and the government to work toward regulating APNs, and that work is ongoing. The leaders of HKAN are instrumental in the process by writing in and meeting government officials, legislative councillor and chairperson of regulatory body to strive for the mission of granting statutory status to APNs through structured education and certification process.

In mainland China, there are neither well-defined core and specialty competencies for APNs in the related areas of practice nor a certification system to confirm their standards. The Guangdong Nurse Association has adopted the curriculum and specialty competencies from the HKAN to educate APNs. In 2017, China issued a key strategic development blueprint to link Hong Kong and Macau with nine mainland cities in the region to form the Greater Bay Area. This initiative involves a number of collaborative projects to leverage the composite advantages of the places to drive business and the economy. The APN collaborative project between Guangzhou and Hong Kong represented an opportunity to deepen the partnership relationship. The HKAN shares the APN curriculum and expertise in providing consultation to its Guangzhou counterparts. In December 2018, a certification assessment exercise was conducted to confirm the standards of 32 Guangzhou nurses working in six specialties (management, medical, mental health, midwifery, pediatric, surgical) and grant them a status equivalent to that of APNs of a similar standard in Hong Kong in terms of education, clinical experience and competence. This is a successful initiative to link education and certification together. The APNs from Guangzhou who participated in the certification exercise have provided clinical documentary evidence and research publications demonstrating their impact on services and the profession. To date, China still has no national system to standardize the competencies, educational requirements and certification system of APNs, in spite of the fact that many provinces are delivering courses based on their own interpretations of what advanced nursing practice should be.

9.3 Conclusion

The account of APN development in Hong Kong and Guangzhou reveals some interesting insights. The evolvement of a profession is a process. It starts with the need for services that challenge the status quo of nursing. From the 1990s to the early 2000s, healthcare services became more complex and specialized. There have

been attempts to enhance quality of care with the support of the appropriate professional talents, and at the same time, there is much pressure to contain costs so as to sustain a cost-effective system. In the midst of these developments, nurses have to differentiate themselves into roles that can claim ownership in specific areas of practice, so that they can make contributions to the evolving healthcare teams. In Hong Kong, these service needs are manifested by the establishment of clinical nurse specialist roles in health care organizations. The launch of the Hospital Authority in Hong Kong with the commencement of a clinical career track in the 1990s was an important start for advanced practice nursing in Hong Kong. The defined need for advanced practice nursing in mainland China is revealed in national documents. It should be noted that the development of nursing in China has been catching up very quickly in the last few decades, since the end of the 10-year Cultural Revolution in 1975. Higher education in nursing in the country was resumed in 1984, with one of the challenges being to increase the acute low ratio of nurses to patients. As of 2018, China had a total of 4.099 million nurses, with a ratio of 2.94 nurses to 1000 population (Wu 2019). This is a big difference compared to 2015, when there were a total of 3.241 million nurses in the country (Wong 2018a). An adequate number of nurses are an important strength in ensuring that nursing does not focus only on meeting essential needs but has a capacity that can build a higher level of practice to lead the profession forward.

The cultivation of talent takes time. As soon as the need for service is identified, the demand for education to prepare these talents emerges almost at the same time. In Hong Kong, the Hospital Authority started its own in-service continued education arm to prepare specialty nurses at around the same period that specialization in nursing was deemed a direction for service. The education sectors were very responsive and began collaborating with the service partners to plan clinical master's programs in both Hong Kong and mainland China.

System and policy support are very important in driving the development of advanced nursing practice. The protection of the title, APN through regulation is a means of safeguarding the public and ensuring the standards of the profession. As APNs work autonomously and employ more complex skills, they need to have proper education and certification of their competencies. Regulation helps to enforce structured proper education in accordance with prescribed standards; in return, the rights and practice privileges of APNs can be protected to ensure optimal care to clients.

In his poem, 'The road not taken', Robert Frost wrote, 'Two roads diverged in a wood, and…I took the one less traveled by, And that has made all the difference.' Every act of professional development is an important move. The service need calls for more advanced professional nursing service, and the quality of service can only be ensured with proper education to prepare nurses with the appropriate level of competencies to deal with increasingly complex client situations. System and policy support are instrumental in legitimizing the APN role to protect the public, and ensure that nurses provide optimal care for their clients.

9.3.1 Epilogue

As an increasing number of nurse leaders will be retiring, younger nurses are preparing to step into leadership roles. While it is clear that clinical experience is crucial for leadership credibility, still a lot of challenges lie ahead for the future young leaders like AW, the second author. One of the biggest challenges is to find ways to sustain the success of the senior nurses who played a pivotal role in healthcare transformation and advancement. In the prologue, FW, the first author, stated that she was involved in a number of strategic works that promoted nursing professions such as the pioneering of nurse clinics, the establishment of the Hong Kong Academy of Nursing and the alliance of key partners in the Greater Bay Area. All of these developments cannot be accomplished without the support from the key stakeholders from the hospitals, government and the nursing profession. For younger advanced practice nurses to fill her boots, we require not only hard work and creative ideas, but also mentoring, encouragement and recognition. By taking the opportunity to work with interprofessional teams, government leaders, and policy makers, all of us as younger leaders can learn, adapt and flourish. At the end of the day, the younger nursing leaders will gain respect from others because of their exemplary work and competencies. It is expected that more strategic works that help promote human health and the professional status of nursing will be developed by a group of young leaders, building on the success of their predecessors. We feel privileged to be able to share our stories in this exciting journey of advanced practice nursing.

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Advanced Practice Nursing in Latin America and the Caribbean

10

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10.1 Introduction

The Pan-American Health Organization (PAHO) is the specialized health agency of the Inter-American System and serves as the World Health Organization's (WHO) regional office for the Americas. PAHO sets health priorities within the Region of the Americas and works to build capacity, mobilize action to address health problems, and to strengthen health systems and services. PAHO is comprised of 52 member countries and territories and operates from its headquarters in Washington, D.C., USA, along with 27 country offices and three specialized centers, as well as partners with nearly 200 Collaborating Centers in 15 countries of the Americas (Pan American Health Organization 2020a). This chapter will describe technical cooperation work of the PAHO Health Systems and Services Department, Unit of Human Resources for Health whose "aim is to guide the design of policies on human resources for health, taking into account that the availability, accessibility, relevance, and competencies of health workers are key to achieving universal health and meeting the objectives of the 2030 Agenda for Sustainable Development (Pan American Health Organization 2020b)."

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In 2013, PAHO/WHO identified the strategic importance of human resources for health (HRH) for the achievement of the goal of universal health coverage (UHC) grounded in the development of health systems based on primary health care (PHC) and approved by resolution to target efforts on increasing access to qualified health workers in PHC-based systems (Pan American Health Organization 2013). The 2013 resolution on HRH provided the foundation to call for a broadening of the scope of nursing practice through development of the Advanced Practice Nurse (APN) role within the Region of the Americas. Universal access to health and UHC (universal health) implies all people and communities have equitable access to comprehensive, appropriate, timely, and quality health services according to need, throughout the life course, without financial hardship, including access to safe, affordable, effective, and quality medicines (Pan American Health Organization 2014). Achieving Universal Access to Health and UHC is a global health systems priority-based on the values of PHC. APN roles can contribute toward attainment of this goal (Valaitis et al. 2017). To this aim PAHO/WHO, between 2017 and 2019, launched three key documents titled "Expanding the roles of nurses in Primary Health Care," "Doctoral Education in Nursing in Latin America and the Caribbean," and "Strategic directions for nursing in the Region of the Americas" (Pan American Health Organization 2017, 2019a, b). These publications and the work leading up to their release were coordinated by the primary author of the present chapter.

This chapter will primarily summarize the document "Expanding the roles of nurses in Primary Health Care." The document's main objective is to provide recommendations to Ministers of Health and other stakeholders in the Region about the role of APNs as an important path for the countries to satisfy their population health needs and to obtain the goals of universal access to health and universal health coverage (Pan American Health Organization 2019a). Other stakeholders, in addition to government, include health services, schools of nursing and midwifery, nurses' associations, and any other entity working with nursing personnel. That document was preceded by "Doctoral Education in Nursing in Latin America and the Caribbean," which presented data on existing doctoral programs in Latin America and the Caribbean and identified gaps within the Region, a barrier to the educational preparation for APN and advancement of evidence-based care (Pan American Health Organization 2017). An action plan was created to expand doctoral nursing programs in Latin America and Caribbean countries. In 2019, PAHO/WHO released "Strategic directions for nursing in the Region of the Americas," which highlighted six crosscutting themes to strengthen nursing and midwifery: policy, leadership, regulation, research, practice, and education (Pan American Health Organization 2019b). The strategy outlined three main lines of action and objectives to guide the countries in the process to strengthen their nursing workforce such as:

1. strengthening and consolidating nursing leadership and strategic management,
2. addressing working conditions and capacities in nursing, and
3. improving the quality of nursing education.

PAHO/WHO disseminated these strategies through summits and webinar series with the aim of building capacity within the Region to expand the roles of nurses in

order for countries to implement the strategy on universal access to health and UHC (Valaitis et al. 2017). Member countries, through continued technical support from PAHO/WHO are working to strengthen their nursing workforce.

10.2 Background: Expanding the Roles of Nurses in Primary Health Care

Direct patient care is the genesis of nursing care, but in Latin America and the Caribbean, the role of nurses mainly focuses on the administrative management of care and health services. In many countries, registered nurses are subordinate to physicians in their actions and have limited professional autonomy. Patient care, at all levels, is in most cases performed by auxiliaries or nursing technical personnel. Registered nurses, despite being the most skilled from an educational standpoint, are few and are generally devoted to managerial activities.

More advanced functions or roles of nurses in primary health care have been implemented in other regions of the world to: improve access to health in areas with a shortage of physicians, maximize access to primary health care services, and enable intensive monitoring of patients with chronic diseases (World Health Organization 2013; Casey et al. 2017; Ter Maten-Speksnijder et al. 2014). However, the countries of the Region of the Americas face difficulties in implementing the role of the Advanced Practice Nurse (APN). Latin America, for example, has neither the regulations nor the training necessary for APNs in primary health care (PHC). The Caribbean, Canada, and the USA are the countries that have gone the farthest in developing programs that have robust education, regulation, and labor market penetration of these roles.

In 2013, the 52nd Directing Council of PAHO adopted Resolution CD52.R13, Human Resources for Health: Increasing access to qualified health workers in primary health care-based health systems, which, among other things, urges Member States to "*promote reforms in health professions education to support PHC-based health systems and increase the number of seats in training programs in the health professions relevant to PHC, including family doctors, advanced practice nurses, and non-physician clinicians, according to priorities and public policies in PHC*" (Pan American Health Organization 2013).

PAHO regards the APN as a professional with an advanced degree who, when integrated into the interprofessional team of first-level healthcare services, contributes to the management of the care of patients/users with minor acute diseases and diagnosed chronic disorders, under the guidance of clinical protocols or guidelines. Expanded professional practice is differentiated from that performed by the public health nurse by the degree of autonomy in decision-making, including diagnosis and treatment of the patient's disorders (Pan American Health Organization 2019a). Another factor to consider is the core competency of advanced practice, such as prescription of pharmaceuticals by nurses, which continues to be prohibited in many countries. In this regard, Mexico has implemented a relatively recent regulation that enables nurses to prescribe drugs in the absence

of a physician in clear emergencies and within the framework of Ministry of Health programs. Nevertheless, Argentina, Brazil, Chile, Colombia, Mexico, Panama, and Peru have a high degree of access to graduate nursing education, and in the future, they could offer the necessary training to APNs and contribute to the introduction of these roles.

The proposed expanded roles for APNs in the countries of Latin America and the Caribbean are:

1. Nurse practitioners: nurses with a master's or doctoral degree, who would care for patients diagnosed with mild acute and chronic diseases;
2. Nurse case manager, who would participate in integrated health system networks, acting as an integrated partner in patient care shared among the levels of care; and
3. Obstetric advanced practice nurse and gerontological nurse, who would care for pregnant women and elderly people.

The role of APNs is based on task shifting and skill mix models. Task shifting is a process of delegation whereby tasks are shifted to reorganize the workforce and make more efficient use of human resources. Task shifting is applied in the health care context as a response to the shortage of health professionals. Task shifting is linked to the objective of promoting a clear and regulated framework that identifies and delimits the care activities and practices of each profession and among different professionals. Task shifting policy is effective and has been successful in several services; nevertheless, it is worth considering the need for conducting long-term studies and evaluating other outcomes over time (Pan American Health Organization 2019b). In the context of task shifting, APNs would perform certain tasks currently within the physician scope of practice in primary health care, in addition to other activities that would include diagnosis and medical treatment, although always using a nursing care model involving prevention, promotion, a holistic approach, and patient- and family-centered care (World Health Organization 2017a). The concept of skill mix can be classified into substitution and diversification. Substitution refers to replacement of one professional by another to increase efficiency, improve outcomes, and reduce costs. Diversification consists of introducing new professional groups to expand the range of skills that can be provided. Diversification would, in this case, better apply to the concept of APNs in PHC, since the intent is not to replace any professionals (World Health Organization 2017a).

Systematic reviews have shown that APNs are effective and have a problem-solving role in primary care. APN roles have also been evaluated in the context of caring for patients with chronic diseases and the results included a reduction in depression, urinary incontinence, pressure sores, and use of mechanical restraints (International Council of Nurses (ICN) n.d.). APNs improve access to primary care services, while reducing costs (Swan et al. 2015). Impact assessments of APNs on health care have shown a high rate of user satisfaction, because nurses tend to spend more time with patients and provide more information and advice. In terms of costs,

when new roles involve task substitution, they tend to reduce or even have no impact on cost (Martin-Misener et al. 2015).

10.2.1 The Role of the Advanced Practice Nurse in Primary Health Care in Latin America and Caribbean

One of the strategies proposed by nursing leaders in Latin America and the Caribbean for improving health services delivery is to review the functions of nursing professionals. Countries which have been developing new functions for nurses have improved access and coverage in certain areas experiencing physician shortages (World Health Organization 2017b; Martinez-Gonzalez et al. 2015; Oldenburger et al. 2016). In Latin-American countries that incorporate the APN role, it will be necessary to standardize a core curriculum for obtaining a degree in each country, so that results from different places can be obtained and compared with reference to international standards. However, each country should also conduct a needs assessment so that universities can offer specialized training in the public health topics that are most relevant to the country context. In this perspective, university programs also need to be updated, while recognizing the years of experience and skills learned (expert programs) by nurses currently working in PHC (International Council of Nurses (ICN) n.d.). Considering the need to establish criteria for training APNs, PAHO/WHO is proposing training plans for registered nurses interested in professional master's level courses in PHC, for recent graduate registered nurses, and for those who are already working in PHC services.

In the first plan (Model 1), registered nurses would be trained as APNs in professional master's degree programs offered by accredited universities, with a PHC approach (Fig. 10.1).

In the second plan (Model 2), registered nurses with professional experience in PHC units would be trained through specific and complementary advanced practice nursing programs offered by accredited universities. The complementary programs would be integrated into a curriculum for theoretical and clinical upgrading, based on core competencies of APN (Fig. 10.2).

Fig. 10.1 Model 1. Education plan for registered nurses

Fig. 10.2 Model 2. Training plan for registered nurses with professional PHC experience

Fig. 10.3 Model 3. APN training plan for recent nursing graduates

In the third plan (Model 3), recently graduated registered nurses would be trained through PHC residency courses in accredited universities and at the end of 2 years they could graduate with a master's degree as APNs (Fig. 10.3).

APN roles are also determined by national laws and regulations. Professional activities are regulated to protect population health by preventing unsafe practices, ensuring service quality, promoting continuing education, and providing users and the public with the best professional competencies. As a result, to make the changes necessary for implementation of APN, current nursing policies and regulations must be adapted in the different countries. Responsibility for regulating the professional role may correspond to Ministries of Health, other governmental agencies, professional councils, or other agencies. Regulation of the APN role is different in each country and at the state level within some countries (for example in the USA). Professional and government agencies, as well as professionals themselves, need to agree to the regulatory process (Jhpiego 2013; Cassiani and Zug 2014).

10.3 Steps to Implement the Role of Advanced Practice Nurses

For the purpose of cooperating with Latin-American and Caribbean countries interested in implementing the evidence-based APN role, nine steps and related activities are proposed (Oldenburger et al. 2016; Bryant-Lukosius and Dicenso 2004) based on the scientific evidence and in the lines of the Strategy on Human Resources for Universal Access to Health and Universal Health Coverage (Pan

American Health Organization 2018), which are described in Table 10.1. The scientific evidence used to develop the implementation steps is guided by the PEPPA framework (Fig. 10.4), or the participatory, evidence-based, patient-focused process for APN role development, implementation, and evaluation (Bryant-Lukosius and Dicenso 2004).

Table 10.1 Steps and activities to implement the role of advanced practice nurses

Steps	Activities
1. Develop human resources for nursing—registered nurses—to advance universal acess to health and universal health coverage and improve patient health outcomes	– Identify population and user profiles by region – Identify users and/or populations requiring PHC as the main focus of activities
2. Identify stakeholders for APN implementation	– Develop collaborative APN networks – Outline strategies by country for introduction of APN roles – Establish interprofessional working groups by strengthening intersectoral actions and community participation – Propose new roles to decision-makers and healthcare providers, strengthening understanding and implementation through work by physicians and other health professionals, health services administrators, and policymakers
3. Determine unmet health needs, based on care priorities, to attain universal health coverage	– Determine health need profiles – Assess unmet health needs of users and in the general population, in order to define a priority-based approach to the functions of APNs
4. Identify priorities and objectives to introduce expanded nursing roles in primary health care	– Set priorities and identify opportunities for new APN roles that are more likely to be successfully implemented – Establish measurable results to evaluate the effectiveness of APN roles
5. Define APN roles in primary health care	– Identify strategies and solutions for the achievement of goals and expected results in each country – Seek and provide technical cooperation for development of a basic set of core competencies
6. Plan implementation strategies	– Describe the roles and contributions of nurses in general, and of APNs in particular – Define four key elements: promotion, commitment, development, and support – Define a plan to formalize legislation and create regulations – Refer to the experience of other countries in regulation and implementation of the APN role
7. Initiate the plan to implement the APN role	– Review and evaluate collaborative efforts among countries, academic institutions, and stakeholders – Develop APN roles, policies, protocols, and regulations – Formulate health policies during the creation of new procedures and directives to facilitate implementation of APN functions – Provide education, resources, and support

(continued)

Table 10.1 (continued)

Steps	Activities
8. Evaluate APN functions	– Review and evaluate APN functions and implementation frameworks – Support scientific research to produce evidence and revise the strategy for future implementation – Develop and support the use of strategies to report to policy- and decision-makers on the effective use of APN functions. The national level also needs an evaluation of general implementation and of the strategy's impact
9. Conduct long-term monitoring of APN functions in the country	– Use the evaluation to identify how the strategies to implement the APN role can be refined to meet additional health needs of the population – Identify whether health needs are being effectively addressed and evaluate what reforms may still be needed

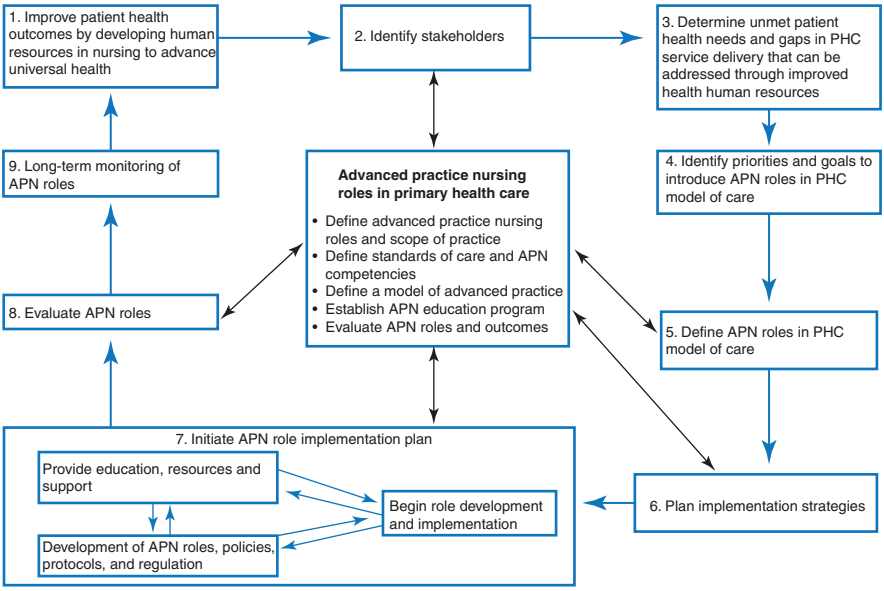

Fig. 10.4 Application of the PEPPA framework to guide advanced practice nursing (APN) implementation in primary health care PHC in Latin America and the Caribbean. Adaptation of the PEPPA framework (Cassiani and Zug 2014), utilizing objectives developed by the participants at the Advanced Practice Nursing Summit, 15–18 April 2015 McMaster University, Hamilton, Ontario, Canada (Oldenburger et al. 2016)

10.4 Dissemination: The Leadership of PAHO in Moving the Region Forward Toward Advanced Practice Nursing

PAHO in its role to support member countries to address APN roles in promotion of PHC in the Americas and to support universal access to health and universal health coverage has been working to disseminate the strategies and action plans described in this chapter. The result has been an increased interest and some progress in Advanced Practice Nursing development in Latin America (Valaitis et al. 2017). Two consecutive summits were held with support from the PAHO/WHO Collaborating Centers in Nursing and Midwifery at:

1. McMaster University, in 2015, comprised of 30 nurses and health care professionals who conducted site visits to observe nurse practitioners in PHC; and
2. University of Michigan, in 2016, aimed to examine core competencies and standards, and identify educational resources, strategies and curriculum to prepare Advanced Practice Nurses in Latin America and the Caribbean.

Guests attended from the countries of Brazil, Canada, Chile, Colombia, Mexico, Switzerland, and the USA (Valaitis et al. 2017). Summit activities included sharing evidence related to APN roles, developing strategies for their introduction into PHC in Latin America, and advancement of the Advanced Practice Nurse role in the Caribbean. A subsequent webinar series, focused on various topics related to APN advancement and PHC, was launched which reached over 500 international attendees. Webinar topics included:

- A Day in the Life of an Advanced Practice Nurse
- Workforce Planning and Analysis
- Introduction to the PEPPA Framework for APN Role Implementation
- Conducting a Needs Assessment: An Essential Strategy
- Strategies for Establishing the Regulation an Effective Implementation of APN Roles, and
- Primary Health Care Nurse Practitioner Education in the USA and Canada.

The summits set planning priorities for this work and led to the implementation of an action plan to achieve the aim of expanding the Advanced Practice Nurse role in the Region. Included within the action plan was the development of a 3-year strategy and a technical working group with member country collaboration. Planning priorities of the 3-year strategy are to:

1. Establish masters-level APN education programs in Latin America and the Caribbean;
2. Engage and influence decision-makers, legislators, and other key stakeholders in Latin America and the Caribbean;

3. Focus APN service delivery on underserved, high-need populations in Latin America, and the Caribbean;
4. Establish a PAHO coordinating center network to develop and implement the Advanced Practice Nurse role; and
5. Define and optimize complementary RN and Advanced Practice Nurse roles in new models of primary health care.

PAHO/WHO continues to progress this work to advance Advanced Practice Nursing implementation in collaboration with its Collaborating Centers and other relevant Latin-American nursing networks in the Region. Several components of a successful approach to develop the role of the APN in new countries were identified in those meetings:

1. International collaboration and partnerships in nursing education;
2. Building on global experts; and
3. Strengthening global understanding and the evolution of APN roles (Valaitis et al. 2017).

These lessons have implications within the Region and beyond to countries globally seeking to broaden or implement Advanced Practice Nursing to expand PHC and achieve universal access to health and universal health coverage.

10.5 Conclusion

The goals outlined in this chapter promote universal and equitable health and the Sustainable Development Goals. These goals depend on everyone, but particularly health professionals who are the human resources in closest contact with key populations. Primary health care is a priority area to improve global health and nursing's contribution has been a key element in this process. The improvement of health outcomes and access to community health services can only be achieved through prioritizing the preparation and training of nurses. Fundamental to this is the support of government and other decision-making bodies to implement policies, health system transformation, regulation and evaluation, expansions of the scope of practice, and certification programs for the continuing education of nurses in Latin America and the Caribbean.

The expansion of the nursing role in Latin America and the Caribbean is an effective initiative in the first and secondary levels of health care to integrate knowledge and generate strategies that provide high quality primary health care where it is most needed. Strategies to reduce barriers to PHC include a clear definition of the APN role, supportive legislation, allocation of financial resources, motivation among stakeholders, and professional recognition. These strategies will be ways to introduce APNs into health care systems, generating a significant step toward achieving universal access to health and universal health coverage in the Region.

Through PAHO/WHO's leadership and technical assistance in the Region, there has been a growing interest in the expansion of the roles of nurses in primary health care in some countries of Latin America and the Caribbean, even without the provision of funding. Many of the activities and initiatives are conducted by universities or nurses in the position of chief nursing officers within Ministries of Health. Significant changes in the region to expand the role of APNs were facilitated by PAHO/WHO through the dissemination of its strategies and new knowledge. Summits and webinars to promote PAHO's publications and initiate the strategy were held with key stakeholders, including nurses, non-nurses, Ministries of Health, and nongovernmental organizations.

However, there is a long pathway until the regulation of an effective labor market for those nurses will be actualized in this region of the world. PAHO/WHO has led the effort to expand the APN role by launching several initiatives in collaboration with member countries; however, the engagement of nongovernmental stakeholders and international organizations outside of nursing could be an additional stimulus to facilitate these initiatives. A collaborative, interprofessional, and intersectoral approach is required to adequately expand the role of the Advanced Practice Nurse globally, an essential step in order to achieve universal access to health and universal health coverage.

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Advanced Practice Nursing in New Zealand

11

Jenny Carryer and Sue Adams

11.1 Introduction

The first Nurse Practitioner (NP) was registered in New Zealand in 2001. By mid-2019, a total of 380 NPs had been registered with the Nursing Council of New Zealand, the regulatory authority responsible for the registration of nurses and NPs (Nursing Council of New Zealand n.d.-a) (see Fig. 11.1). Of these, just over half are thought to work in primary health care and community settings, including general practice (family/primary care practices), older adult care, palliative care, mental health, and sexual health. Other NPs work in hospitals (acute, rehabilitation, and long-term care), ambulatory settings, and in roles that help patients navigate between primary and secondary care services. Over the past two decades, considerable changes and clarification have been made to educational requirements, processes for registration, and legislation governing NP regulation and practice. Such changes have enabled a NP to work at a comparable level to a primary care physician as an authorized prescriber and access government funding to deliver mainstream primary care services to local populations. Within the hospital environment, NPs are generally considered to work at an equivalent level to registrars (a medically trained practitioner with at least 2 years postgraduate experience).

New Zealand has a population approaching five million people and a land mass that approximates California or the United Kingdom. While the majority of the population are of European descent, 15% are Māori (the indigenous people of New Zealand),

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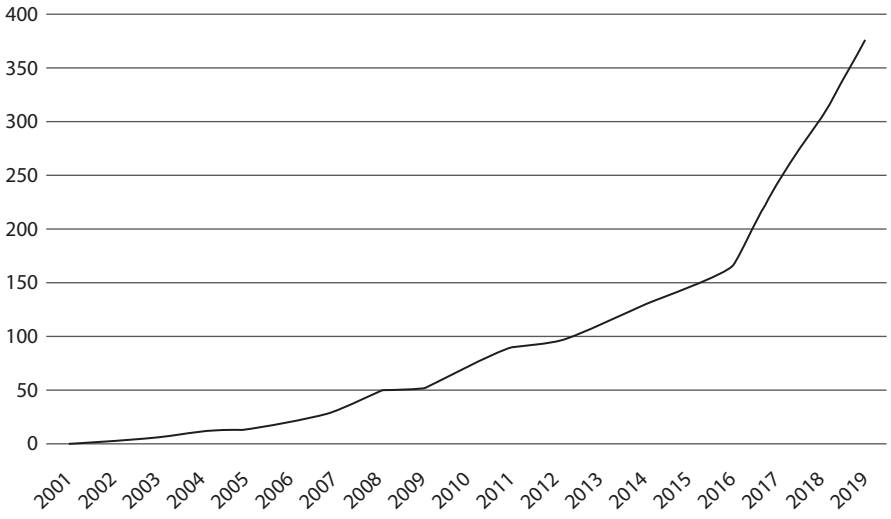

Fig. 11.1 Growth of NPs in New Zealand. Data taken from annual reports provided by Nursing Council of New Zealand (Nursing Council of New Zealand n.d.-a)

7.5% Pacific, and 12% Asian. New Zealand, as in other countries, is facing a rising older population, increasing prevalence of long-term conditions, persisting health inequalities, all compounded by an over-stretched health service, a health workforce shortage, and increasing scarcity of primary care physicians (known as general practitioners in New Zealand). The opportunity for New Zealand to fully implement the NP role as mainstream, particularly in the primary health and community care sectors, has yet to be taken on board as a solution to current demographic, workforce, and health equity concerns (Carryer and Adams 2017; Adams and Carryer 2019).

In New Zealand, the development of advanced practice nursing, and more specifically that of the NP role, has been driven almost entirely by a small group of nurse leaders, pioneering clinical nurses, and academics who have worked from various angles over the last 20 years. Their work has been captured through a small number of doctoral theses (Jacobs 2005; Pirret 2013; Wilkinson 2007; Adams 2017) and other publications (Jacobs and Boddy 2008; Carryer and Yarwood 2015; Ministry of Health, Nursing Council of New Zealand, DHBNZ, NPAC-NZ 2009). More recently, given that we now have sufficient NPs for useful data collection, local research is emerging to add to the body of international literature (Carryer and Adams 2017; Adams and Carryer 2019; Carryer et al. 2011; Gagan et al. 2014; Pirret 2016; Pirret et al. 2015).

11.2 The Development of the NP Role in New Zealand

In 1998 in New Zealand, a Ministerial Taskforce on Nursing (Ministerial Taskforce on Nursing 1998) determined (amongst other recommendations, including nurse prescribing) that it was timely to develop an advanced practice nursing role, and

agreed that this role would be the *nurse practitioner*. The strong union presence of the New Zealand Nurses Organisation (NZNO) initially objected to the need for masters-level education, arguing that clinical experience was an adequate prerequisite for advanced practice and specialist nursing roles. With nursing leadership provided through the College of Nurses Aotearoa (New Zealand), national consensus-making workshops were facilitated. Further, the NZNO consulted widely and in 2000 reversed its previous position, recommending the need for postgraduate education for advanced practice nursing roles. Clear agreement was ultimately reached within the nursing profession about the way forward for New Zealand NP development as outlined in a Ministry of Health publication (Hughes and Carryer 2002).

Perhaps most significantly, nursing leaders determined the title *nurse practitioner* would have a separate scope of regulated practice and the title would be endorsed by the national regulator, the Nursing Council of New Zealand. In order to protect the title prior to the enactment of the Health Practitioners Competence Assurance Act (Health Practitioners Competence Assurance Act 2003), the Nursing Council trademarked the term *nurse practitioner* in 2001. Importantly, these steps have not only enabled the Nursing Council's legislative functions to protect public safety, by ensuring all NPs are competent and fit to practice, but also clarity has been given to the public, policy makers, and health professionals regarding the scope of the NP role. The first NP scope of practice was published in the New Zealand Gazette (the Government's journal of constitutional record) in 2004. The scope was considerably revised in 2017 following extensive consultation, and particularly to include that NPs are authorized prescribers, and is shown in Box 11.1.

Box 11.1: Scope of Practice of NPs in New Zealand (2017) (Nursing Council of New Zealand n.d.-b)

Nurse practitioners have advanced education, clinical training, and the demonstrated competence and legal authority to practice beyond the level of a registered nurse. Nurse practitioners work autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and improve access and population health outcomes for a specific patient group or community. Nurse practitioners manage episodes of care as the lead healthcare provider in partnership with health consumers and their families/whānau. Nurse practitioners combine advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to provide patient-centered healthcare services including the diagnosis and management of health consumers with common and complex health conditions. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic and laboratory tests, prescribing medicines within their area of competence, and admitting and discharging from hospital and other healthcare services/settings. As clinical leaders they work across healthcare settings and influence health service delivery and the wider profession.

Nurse practitioners in New Zealand are required to be experienced registered nurses having completed a clinical master's degree in nursing, and demonstrated the required advanced practice competencies (Nursing Council of New Zealand 2019) (see Box 11.2). Funding for postgraduate education is available on application through a workforce division of the Ministry of Health. At the outset of the NP project, nurse academics recognized that while the master's degrees had a strong social science focus, the programs would need rapid development to include the core requirements of a clinical master's degree to support advanced practice nursing. Programs were required to include pathophysiology, advanced assessment and diagnostics, pharmacology, and prescribing practice.

Box 11.2: Qualifications for NP in New Zealand
From: *Nurse practitioner scope of practice: Guidelines for applicants* (p. 4) (Nursing Council of New Zealand 2019)

(a) be *registered with the Nursing Council of New Zealand in the registered nurse scope of practice*
(b) *complete an approved clinical master's degree programme (or overseas equivalent) for the nurse practitioner scope of practice. The programme must include relevant theory and a minimum of 300 h of clinical learning*
(c) *at least 4 years' experience in an area of practice*
(d) *pass an assessment against the nurse practitioner competencies, given by a Council-approved assessor*

When the NP role was launched in New Zealand in 2001, the intention was that NPs would address broad population groups rather than specific disease categories or locations of practice. Possibly due to the reservoir of experienced senior clinical nurses and the clinical nurse specialist roles in discrete areas of practice, early NP candidates tended to be located more frequently in specialized or disease-specific areas, such as neonatology, gerontology, and diabetes. For primary health care, specific postgraduate programs provided the leverage for nurses to progress through their postgraduate education to a master's degree, such as the rural nurse specialist diploma in the South Island, while other healthcare initiatives targeting areas, such as health inequalities and long-term conditions, prompted tertiary education institutes to develop specific postgraduate programs. The result was a range of different tertiary institution providers delivering a myriad of diverse courses leading to a clinical master's in nursing.

Over the years, the variety of papers available within master's programs has reduced while retaining the required 240 credits. The consequence has been that while the biomedical components of the programs have strengthened, the focus on population health, social justice, ethics, and other more nuanced subjects has perhaps diminished. The challenge is going to be how New Zealand ensures that the NP role continues to bridge the biomedical-nursing paradigm.

The Nursing Council of New Zealand has recently reaffirmed the commitment to ensuring that a NP is able to provide a broad spectrum of care. Since 2017, NPs are no longer restricted by a condition stating a specific area of practice, but as advanced practitioners are "trusted" to practice within their areas of competence and experience (Nursing Council of New Zealand n.d.-b). Such broad areas of practice include mental health, primary health, elder care, or care of children and young people. The educational preparation addresses the breadth of requirement by providing students with the framework for advanced nursing practice, which can then be applied to the context of their proposed advanced practice setting or specialty. Because New Zealand is a small country with limited population densities in any one city, NP education has been shared jointly in a clinical master's program with students who may not be intending to seek authorization as a NP. The NP candidate is differentiated by completion of the 1 year supervised (academic and clinical) practicum as a component of the master's degree to meet the required NP competencies, including prescribing practice (Nursing Council of New Zealand n.d.-c). The key NP competency themes, revised in 2017 (shown in Box 11.3), are further divided into multiple indicators. Clinical practice experience is supervised and completed in the employment situation. Concern with completion of specified hours of practice has not been a feature of the pathway in New Zealand. Hours have been addressed by requiring those entering the program to have at least 3 years prior nursing experience, the usual period of completing the degree, which is generally 4 years, at least, and the ability to demonstrate achievement of the competencies upon application.

Box 11.3: Themes Under Which NP Competence Is Assessed in New Zealand
From: *Competencies for the nurse practitioner scope of practice (*Nursing Council of New Zealand n.d.-c*)* (p. 1)

1. Provides safe and accountable advanced practice
2. Assesses, diagnoses, plans, implements and evaluates care
3. Works in partnership with health consumers
4. Works collaboratively with healthcare teams
5. Works to improve the quality and outcomes of healthcare

A recent change has occurred in New Zealand with the commencement of government funded programs in two universities. These programs require the candidate to have completed at least half of the master's degree upon entry, to have employer agreement that they have a NP position upon successful completion and will complete two specific practicums requiring 500 hours of clinical practice. After completion of the clinical master's degree, applicants for NP authorization compile a portfolio demonstrating how they meet the NP competencies. Nursing Council conducts a desk audit of this document and, if the portfolio is satisfactory, the applicant progresses to attending an oral viva with an assessment panel. After this process, NP authorization may be conferred.

11.3 Challenges in the New Zealand Health Sector

A prolonged and interesting tension has occurred between the stated policy intentions of the New Zealand Government (Hughes and Carryer 2002) and the actual willingness to implement the NP workforce. Nurse leaders have had to work consistently and strategically to circumvent layers of obstruction and inactivity in order to progress the role. We will discuss several possible reasons for the very slow progress.

New Zealand has a hybridized health system with free hospital care but both primary health care and aged residential care are run under a private business model, albeit with heavy government subsidization and a requirement for patient co-payment. Theoretically, no one in the country should have limited or no access to care and services. However, New Zealand has many rural and demographically isolated areas and many small towns with low population numbers. The country has significant child poverty, homelessness, and high levels of health disparities between the most well off and those on low incomes or welfare benefits. Māori, our indigenous population, are disproportionately represented amongst the most vulnerable (Ministry of Health 2015) and the need to achieve equity remains a major challenge. Downes (2017) reported that 30% of New Zealanders are not able to access timely primary care (Downs 2017). Despite the rhetoric, a great many people in New Zealand have unmet needs who would be well served by a large workforce of NPs (Carryer and Adams 2017).

Since the Ministerial Taskforce on Nursing in 1998 (Ministerial Taskforce on Nursing 1998), it has become even more evident that a different approach to service delivery is urgently required. From the Ministry of Health to the front line we now recognize that old ways of doing things and a reliance on the traditional workforce configurations designed to meet acute biomedical care will not address unmet needs. Internationally, the WHO (2008) and others have called for redesigned health systems to transform the primary care workforce and delivery models with nursing central to such changes (Commission on Social Determinants of Health 2008; Bodenheimer and Bauer 2016; Pittman 2019; All-Party Parliamentary Group on Global Health 2016). However, despite various governmental strategies, discernible change for service users has been slow to materialize.

At the policy level Ministry officials have made frequent high-level calls for innovative disruption (Christensen et al. 2015), suggesting that the health sector is ready and willing to change from traditional medical models of service delivery. Multiple health strategies and action plans have been written and published by the Ministry of Health (Ministry of Health n.d.) with similar themes, including for primary health care, Māori, healthy ageing, suicide prevention, alcohol misuse, gambling, palliative care, and cancer control. These themes include calling for attention to health disparities, improving preventative care, managing the tide of long-term conditions more effectively, and increasing the use of the whole workforce at the top level of their license potential. The extent to which these strategies have ever been implemented is questionable, as while the vision has been exemplary, the operational structures or policy settings have not

supported or facilitated the desired change and have certainly not supported any notion of significant disruption (Robertson et al. 2015).

One example has been the implementation of The Primary Health Care Strategy (Ministry of Health 2001), launched in 2001, which resulted in major structural changes to the sector. The strategy promised a population health approach to improve access to comprehensive primary healthcare services and remove health inequalities. Substantially increased government funding, in the form of capitation payments, meant in effect that services were purchased in advance on behalf of patients with the expectation that the service would be delivered by the best person to do so. This move was intended to increase the use of the wider multidisciplinary team and was seen as a way of validating the work done by nurses in such settings. The need for advanced practice nurses with a clearly defined career pathway, appropriate education, and improved employment arrangements was considered central to the success of the strategy. However, it quickly became apparent that medical practitioners, as practice owners, tended to regard the capitated funding as their direct income, or at least income over which they had jurisdiction. In reality, the transformational changes that had been anticipated through the strategy were not realized (Cumming 2016; Finlayson et al. 2012) and physician-led care has prevailed.

Through her doctoral research, Adams (Carryer and Adams 2017; Adams and Carryer 2019; Adams 2017) critically examined the establishment of NPs in rural New Zealand using institutional ethnography. Underpinned by a nursing paradigm that promotes social justice and health equity, the research explicated how both the neoliberal health policy environment and medical hegemony maintained the status quo, limiting the establishment of the rural NP workforce. Service fragmentation, a competitive and changeable funding environment with rapid turnover of contracts, and the ongoing policy support of small business models of general practice hampered the opportunity for health providers to invest in the NP workforce. Further, while the shortage of rural primary care physicians was considered critical, there was little willingness at all levels of the health sector to actively support and promote NPs as a solution. The rhetoric, presented through the national media, centered on schemes to recruit and retain physicians. However, despite such an adverse environment, years of sheer determination by nurse leaders together with extraordinary pioneering NPs has resulted in a growing number of NPs establishing service delivery.

11.4 Nursing Leadership and Ongoing NP Role Development

From the outset, nursing in New Zealand, under focused leadership, agreed with and aimed to support the vision behind the various strategies and policies. The commitment to the NP project has been supported by international evidence demonstrating the health outcomes achieved by NPs and their cost-effectiveness (Laurant et al. 2018; Swan et al. 2015; Martínez-González et al. 2014). Further, the nursing profession supported by the Nursing Council of New Zealand has acknowledged the contribution NPs can make to the health of New Zealanders.

The impetus towards the NP role in New Zealand has never been about a substitute for medical services but a serious attempt to reframe or transform the processes of service delivery. Kooienga and Carryer (Kooienga and Carryer 2015) have previously argued that:

> After 100 years of health services framed by the culture of medicine, most countries report an epidemic of chronic disease, a resurgence of infectious diseases related to poverty, huge inequalities in access and outcomes, major expenditures occurring in the last year of life, and often insufficient investment in child and youth health. (p. 806)

However, it appears that medical hegemony remains strong at both overt and covert levels. While the rhetoric of reducing the burden of long-term conditions and health inequalities are evidenced in, for example the New Zealand Health Strategy 2016 (Ministry of Health 2016), even health bureaucrats are unconsciously invested in the maintenance of medicine as the default leadership position and the default solution to service gaps. Initial resistance by the medical profession to the development of the role was inevitable, challenging, and persistent, but is perhaps at last declining. Now many primary care physicians who work with NPs have recognized their contribution and value to the health of their communities.

Since the role was first mooted, we have participated in a steady process of eliminating barriers to practice through lobbying for and achieving legislative change. Changes to the Medicines Act (Medicines Amendment Act 2013), enacted in 2014, saw NPs achieve the status of authorized prescriber, the same level of prescribing autonomy as held by medical practitioners. A few years later, the Health Practitioners Statutory References Bill (Health Practitioners 2015) removed references to medical practitioner from eight separate pieces of legislation and changed the wording to either health practitioner or added NP alongside medical practitioner. These changes have freed up NPs to sign death and cremation certificates, sign "off work" certificates, and various other procedures. Other challenges have included securing the right for NPs to prescribe special authority medications, controlled drugs, and to write standing orders for other practitioners. All has been achieved, at this point, with one exception—that an NP cannot yet order ultra-sound for the first trimester of pregnancy prior to the woman's care being passed directly to a lead maternity care provider, most usually a midwife. Changing this barrier requires attention to the Public Health and Disability Act (New Zealand Public Health and Disability Act 2000), section 88.

At the same time a steady process of successful policy challenge has occurred as NPs are now able to claim for first specialist assessments in hospitals, carry out required regular assessments and treatment plans in residential care facilities, and to claim the same government funding streams as general practitioners (primary care physicians) working in community settings and primary care practices. At this point all other funding streams are accessible by an NP with the minor exception of the Accident Compensation Commission[1] which persists (despite lobbying) in paying a

[1] The Accident Compensation Corporation (ACC) is New Zealand's universal no-fault scheme for work and non-work injuries. The scheme provides contributions to treatment costs, loss of earnings, return to work schemes, and home and vehicle modifications.

NP a different amount than a GP for delivering exactly the same service to a patient. These changes have created a platform for the viability of the role as a valuable addition to the New Zealand workforce. However, many challenges remain, which are proving more difficult to overcome.

While many barriers were concrete and amenable to legislative or policy change, other barriers relate more to persistent custom and practice and levels of ignorance amongst managers or medical leaders. One example, which captures this phenomenon, has been resistance to a NPs right to order radiology tests. Despite clear documentation that NPs are legally able to order radiology tests, we have seen repeated examples of service managers or radiologists professing their certainty that this cannot happen. In such circumstances, patients' care is held up or even compromised. Additionally, certain specialist medical practitioners have also professed reluctance to accept referrals from NPs. In one instance, the specialist noted that while this was the most comprehensive referral letter ever received, it would not be accepted. Such behavior, while not legitimate, requires firm challenge especially if patients are not to suffer through delayed care.

New Zealand nurse leaders are proud to have resisted the process of medical appeasement and can note that the role in New Zealand carries no requirement for oversight, supervision, protocols, enforced or formal collaboration nor limits to prescribing. Nurse practitioners in New Zealand have an enviable amount of freedom and autonomy to practice their craft without impediment and frustration created by supervisory relationships.

The uptake of the NP role in New Zealand thus proceeded initially at a glacial pace with considerable wastage of investment and energy. The momentum is now gathering considerable speed. According to Ministry of Health workforce data in 2019, in addition to NPs, a further 2000 registered nurses hold a master's degree and are potentially eligible to apply for an NP role. This represents a considerable potential resource for addressing health deficits and general practitioner shortages.

Media accounts are released almost daily, which report the rapid decline in availability of primary health physicians for many New Zealanders (Royal New Zealand College of General Practitioners 2019). The NP role alongside RNs working to the top of their scope stands poised to provide the exact new or "disruptive" model of service for which frequent calls are made. A persistent challenge over the years has been to encourage the media to take up the positive news about the growth of NPs and their potential. Instead, the media have focused on the crisis of the shortage of primary care physicians, perpetually seeking solutions that maintain a sector dominated by medicine.

In 2019, with a major review of the health system under way, it is clear that primary care physicians are determined to protect their private business model, despite significant reports of its flaws and the lack of attention to the needs of the most vulnerable (Downs 2017). A national patient care survey was launched by the Health Quality Safety Commission New Zealand (Health Quality and Safety Commission New Zealand 2019). In a most subtle form of resistance or ignorance, NPs were omitted as an option that respondents could select to identify as their provider. This occurred despite the fact that a fairly significant number of people are

now enrolled with an NP as their primary provider. Nursing leadership challenges to this omission were not successful during the drafting of the survey.

In New Zealand, we are seemingly producing a health workforce of NPs who are small in numbers, largely because of the barriers (mostly now imagined), conflicts, and vested interests associated with a partly private and partly publicly funded system of service delivery for primary care services. The net result is that the focus of health service development and investment has remained very much on primary care as the narrow response to presenting acute problems rather than the intended focus on the broader and much needed concept of primary health care. This continued focus on first contact medical care is at the expense of appropriate care for children in the first 1000 days of life, attention to the growing mental distress of young people, the vast numbers of people living with complex comorbidities, an ageing population, and the health inequalities facing indigenous and other deprived and vulnerable communities.

Nursing leadership in NZ has been advancing the NP role in the belief that there is genuine impetus for change. Despite the fact that an NP is now (and has been for many years) a fully viable income generating member of a general practice team, the myth is still widely promulgated that general practice cannot afford to employ NPs. This development is frustrating and can only be addressed by time and attempts to publicize the facts. We have hope in many practices where NPs are working successfully and collegially alongside medical colleagues. Nursing is also optimistic that as the focus on the lack of equity for much of the NZ population intensifies then greater attention will be provided to NPs as a solution.

11.5 Social Justice and Health Inequalities

Māori, the indigenous people of New Zealand, experience significant health inequalities. Socio-economic determinants and low health literacy relate to poorer health outcomes for life expectancy and morbidity across the life span, including long-term conditions, cancers, oral health and rheumatic fever; and smoking prevalence, obesity, alcohol and drug use, gambling, suicide rates, and family violence remain unacceptably high (Ministry of Health 2015; Marriott and Sim 2014). New Zealand is a bicultural nation based upon its founding document, the Treaty of Waitangi, yet despite the principles of the Treaty being incorporated into health service policy in the late 1980s, institutional racism persists (Came 2014). The reductionist biomedical western models of health care that predominate do not meet the needs of Māori and require alternative, culturally appropriate models (Came 2014; Sheridan et al. 2011; Durie 1998).

New Zealand NPs in primary health care work within a social justice paradigm, embracing principles to promote health and well-being, and reduce health inequalities for individuals, families, and communities (Carryer and Yarwood 2015; Browne and Tarlier 2008). One of the nursing professions' key strengths in New Zealand has been the adoption of Irihapeti Ramsden's (Ramsden 2015) work on cultural safety. This has manifested in the development of an educational framework to analyze the

power relationships between health professionals and those with whom they work, particularly Māori. Striving for an approach that understands and accommodates cultural difference is a key component of all nursing education and a required competency for nursing practice.

A number of the extant NPs in New Zealand have established their work in rural and Māori communities, in precisely the locations necessary to achieve the international and national goals of the Primary Health Care Strategy (Ministry of Health 2001; World Health Organization 2018). Through our qualitative research (Carryer and Adams 2017; Adams and Carryer 2019), we have learned that NPs are passionate about the health of their communities and work in ways that demonstrate their commitment to improving health and well-being. Such NPs have worked to reshape health services and inform policy direction. They model how to work across organizational and policy boundaries, focusing on the social, cultural, and political contexts in which people live and work (Adams and Carryer 2019).

11.6 Future Hopes and Challenges

A new phenomenon occurring in the last year or two is a rapid increase in the number of advertisements for NP positions especially in general practice or community settings and to a lesser extent in palliative and aged care. Advertising for an NP at this early stage assumes that there are many NPs actively job searching which is not the case. Rather we have advocated for a "grow your own" approach as it is far more successful for such settings to identify their RNs who are on the pathway to holding a clinical master's degree and formally recognize them as NP candidates with a future position available. Registered nurses are the only health workforce well distributed across NZ and as such, they are a resource worthy of investment towards advanced practice. In this case, a small investment will pay quick dividends in meeting unmet need.

The strength of the NP role, as it was anticipated, was to provide patients with access to nursing care in the course of consultation and management of presenting problems. Such work, if done properly, takes time and is challenged by the tyranny of the acute and the time pressures, which characterize general practice and many other settings especially when driven by a profit agenda.

Our next challenge is now becoming clear as primary healthcare NPs especially find themselves under pressure to work faster and see patients in short appointment times in order to secure profit for business owners. This contrasts strongly with their desired focus on the social determinants of health, their awareness of equity issues, and the value of improving health literacy and health education. As previously noted, the entire health system in New Zealand is the subject of a government commissioned major review process. Nurse leaders need to clearly articulate the value of NPs as a role with a strong primary health care and social justice focus (Browne and Tarlier 2008). To this end there is growing global support.

The World Health Organization (WHO) has long recognized that a new model of healthcare delivery is required to meet the current global health crisis

(Commission on Social Determinants of Health 2008). In New Zealand, we have determined that NPs offer the exact transformation in care that the WHO seeks. As we have previously argued (Carryer and Adams 2017), NPs can only deliver the full transformative potential of the role if the nature of their employment facilitates rather than limits their practice. We argue that the impetus of NPs towards transformative care must not be inhibited by funding patterns or management decisions, which continue to suggest medical solutions to health problems arising from lack of equity, lack of access, and lifestyles constrained by homelessness, poverty, and poor nutrition.

In order to support this perspective, we challenge the international impetus to continue conducting research demonstrating direct comparisons or equivalence between nurse practitioners (NP) and physicians or physician-led care in terms of outcomes. This work has been done and done well and the findings are unequivocal (Laurant et al. 2018; Swan et al. 2015; Martínez-González et al. 2014). Such research however strengthens a world view that the NP role is a substitutive role rather than one of promoting service transformation. More importantly, the future research focus could be on demonstrating how NPs, when given the freedom and autonomy and appropriate employment settings, can provide a type of care which spans medicine and nursing and health and offers a qualitatively different but much needed type of care. Capturing short and long-term outcomes of transformative care by NPs is vitally important if models of care are to be genuinely redesigned.

The establishment of the NP role in New Zealand has been a 20-year journey, which is finally gaining real impetus. Nursing leadership activity has been persistent and courageous in combatting both visible and covert barriers to the role establishment. Perhaps we have too often naively assumed that the high levels of unmet need should be sufficient to ensure receptivity, but it has not been so. Health is a business, first and foremost, even in this country of largely free health care, and the powerful historical acceptance of medical leadership continues to shape the debate.

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Advanced Practice Nursing in the United Kingdom

12

Melanie Rogers and Annabella Gloster

The United Kingdom (UK) is comprised of four countries, England, Scotland, Wales and Northern Ireland. Whilst the UK has a central Government, which has overall authority, it is important to recognize that Scotland, Wales and Northern Ireland each have a devolved government, which are responsible and accountable for developing their own countrywide policies, including health policy. This has led to the four countries developing advanced practice in response to their specific needs.

This chapter provides an overview of the development of advanced practice in each country. More detail from England is evident due to the length and extent of its advanced practice developments. Throughout the chapter, the development of advanced practice is exemplified through nurse leadership illustrations.

12.1 Overview of Advanced Practice in the United Kingdom: Introduction

Advanced Practice Nurse (APN) roles started in the UK in the 1970s initially with the development of the Clinical Nurse Specialist (CNS) role (Hill 2017), followed by the development of the Nurse Practitioner (NP) role in 1988 (Stillwell 1988). As with many countries, the drivers for the development of APN roles included the changing health needs of the population, a shortage of medical providers, reduction

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of junior doctor working hours, as well as a desire to advance nursing (Sheer and Wong 2008; Nadaf 2018). The UK has seen a consistent drive to recognize these roles integrating the best of nursing with the best of medicine to provide holistic care to patients rather than a physician substitution or task-shifting role (Bindless et al. 2007).

In the UK, the NP and CNS roles are not regulated and historically do not have title protection. The lack of title protection has led to multiple issues across the UK including variation of education, titling, and role confusion. In addition, the NP role has progressed to a more advanced level of practice compared to the CNS, role which has often focused on specialized nursing. Initially, the NP role developed mainly in primary care due to a crisis in medical provision. Secondary care NP developments started in the early 2000s with the role of NP in the emergency department and urgent care settings. The distinction between the CNS, who works in specialized fields, and NPs, who have a more generic focus, has become clearer over time. Advanced Practice Nurse (APN) is not a well-recognized or utilized title in the UK, the term Advanced Practice (AP) is more commonly used and will be referred to throughout the chapter.

12.2 Development and Leadership of APN Roles in the United Kingdom and Inception of APN Roles

Advanced practice has slowly evolved in the United Kingdom (UK) with the origins of the Nurse Practitioner (NP) role being attributable to the pioneering work of Dr Barbara Stilwell (see Chap. 3) who introduced the role into primary healthcare in the late 1980s (Stillwell 1988). She was inspired to become an NP whilst working in a deprived area in inner city Birmingham in the UK. She was working with many families from the Indian sub-continent who felt unable to access the healthcare they needed as male physicians provided much of the care. She recognized that her skills and knowledge as a nurse were being under-used. Having read about NPs in the United States, she decided to train as an NP in North Carolina. Post qualification she returned to the UK to work in Birmingham.

Barbara tried to set up the first NP programme in Birmingham but faced a lot of resistance from physicians who were worried she wanted to usurp their roles and also nurses who were worried they would be giving up nursing if they trained to be an NP. Barbara had a vision to create a new role for nurses who could revolutionize healthcare. She was convinced that the NP role would bring benefit to patients and the health service in the UK so pushed forward and developed the first NP programme in 1989, taught at the diploma level, in London through the Royal College of Nursing (RCN), the UKs largest nursing membership organization and trade union. The programme was based on a curriculum that required competence in physical health assessment, differential diagnoses and patient management skills with the underpinning knowledge of anatomy and pathophysiology. Barbara has said, “I’m very proud of what we achieved. It is self-evident that nurse practitioners are cost effective and fulfil a need” (London South Bank University 2016).

Her work to convince physicians of the benefit of the role, and nurses that they would not be giving up on nursing but providing the best of nursing and medicine, created opportunities for advanced practice to really develop in the UK. Barbara consistently advises nurses to "be the leader you can be today. Don't get too hung up on the future and what might happen. Focus on what you can control and what you can achieve right now" (Stilwell 2019). For Barbara this involved undertaking training in another country to meet her patients' needs, then to train other nurses in the UK.

One of the NP students Barbara taught in the UK was Katrina Maclaine whom many view as one of the most significant leaders within the whole of the UK and who has supported and championed the development of advanced practice. Whilst working in the East End of London she taught in the RCN NP programme for many years before moving to London South Bank University where she is the Course Director for the multi-professional MSc Advanced Clinical Practice. Katrina has worked extensively with the RCN, government bodies, universities, and international organizations to develop regulation, health policy, and education for advanced practice.

Katrina is a founding member and current chair of the Association for Advanced Practice Educators (AAPE UK) UK, which currently has members from 50 universities. She has supported the leaders across the UK in their advanced practice developments and has led national and governmental discussions regarding advanced practice over the past two decades. Part of her national work in England has been to develop and implement a multi-professional framework for advanced clinical practice in England (Health Education England 2017) in addition to developing the standards for the new Advanced Clinical Practitioner Apprenticeship (Skills for Health 2017). Advanced practice apprenticeships are unique to England and allow a combination of study (off-the-job training) and workplace learning (on-the-job training) funded by a tax to be reclaimed against training for employers.

Many advanced practitioners view Katrina as a role model who has worked tirelessly to support regulation and standardization of AP roles. Her ability to influence health policy and AP developments has been instrumental in advancing the role. Her leadership skills have inspired a succession of AP students to develop their own significant leadership roles both nationally and internationally. Like Barbara, she has faced many challenges including how to promote the benefit of NPs as clinicians, leaders, educators and researchers as well as ensuring that new development for advanced practice builds upon existing evidence-based practice. She has recognized that as a critical mass of APs in the UK grows, more patients and stakeholders experience the benefits and then the APs' true worth can be recognized.

12.3 The Association of Advanced Practice Educators: Development and Leadership

In 2005, The Association of Advanced Practice Educators UK (AAPE UK) formed, initially called the Association of Advanced Nurse Practitioner Educators (AANPE). The association flourished with an affiliate membership with the National

Organization of Nurse Practitioner Facilities (NONPF) which developed after a meeting between Mike Walsh (Chair of AANPE), Helen Ward (Deputy Chair) and Michelle Beauchesne, a NONPF board member, who outlined the terms and conditions for the UK to become an affiliate member of NONPF. After attending a national NONPF conference in 2004, the association received support from NONPF to become an affiliate.

AAPE UK has grown significantly and is now an influential collaborative network of leaders from Universities across the UK who are providers of AP programmes of education for not just nurses but also allied health professionals developing advanced practice. AAPE UK, independently and with other organizations, provides information on research, education and contemporary advanced clinical practice, providing support to its members and acts as a resource in the UK. AAPE UK responds to government consultations and promotes debate on emerging issues related to AP.

The committee members are all actively leading advanced clinical practice developments in their own regions in collaboration with policy makers, clinicians and employers. They are helping shape the future leaders (AP students) through their educational programmes. The committee members have all worked as NPs or advanced practitioners with some still practising in conjunction with their educational role.

Developments that have been driven by AAPE UK or by individual committee members include the development and implementation of the first national NP programme in Northern Ireland; the development of Academies of Advanced Practice in Scotland; and the development of specialty specific curricula for AP within England.

Working with Katrina through AAPE UK to develop AP in all four countries were David Barton (Wales), Douglas Allan (Scotland) and Donna McConnell (Northern Ireland).

David Barton was influential within Wales acting as chair of the Advanced Practice Framework Group. The Welsh AP Framework group ensured standardization of all NPs who were using the title through the mandatory use of a portfolio that was (and still is) assessed against standards to ensure that individual NPs are able to demonstrate and evidence their advanced level practice. The group intended that the portfolio be used as a resource within the employer/employee annual appraisal process. The portfolio data has also been used to develop and maintain a database of NPs. David Barton was instrumental in this database development where portfolios are reviewed by local health boards on an annual basis (National Leadership and Innovation Agency for Healthcare 2010a). Only NPs on the database are able to practise and use the title NP.

Douglas Allan was an influential nurse within Scotland having held responsibility for overseeing all health and social work related masters programmes at Glasgow Caledonian University and was Chair of AANPE from 2010 to 2014. Douglas had an active interest in advanced practice and was a member of the NHS Education for Scotland (NES) Advanced Practice Succession Planning Steering group who developed the advanced practice toolkit that has been widely utilized in the UK (NHS

Education for Scotland 2008). The toolkit provides a UK wide resource of resources to support the development of advanced practice training and education.

Douglas Allan and David Barton co-edited the first advanced nursing practice book with a UK focus, which included contributors from the member universities of AAPE UK (Barton and Allan 2015).

Donna McConnell has been instrumental in the development of the NI developments. Donna is an NP graduate from an accredited NP programme in 1997 and set up the NP service within her emergency department. She was a member of the steering group that developed the advanced nurse practitioner framework and the subsequent competencies for Northern Ireland in 2014 (Department of Health, Social Services and Public Safety 2016). Donna was also involved in the development of the ANP programme at the University of Ulster that commenced in 2017 having maintained her clinical work as an NP and completing her doctoral studies on exploring person-centredness in the emergency department.

These leaders all have taken risks to ensure that advanced practice remains a focus for health policy developments. They have worked tirelessly to ensure that each of their countries is represented at a national level in advanced practice developments and have acted as representatives for the advanced practitioners training and working in their countries. One of the key areas each have lobbied for is for the standardization and regulation of advanced practice in the UK. Scotland has progressed more quickly than England with these developments.

12.4 Clarification and Regulation of Advanced Practice Roles in UK

Early decisions made as AP roles have developed in the UK and lack of nursing leadership has led to far-reaching consequences that are taking time to address. Issues including inconsistent health policy, education, regulation and title protection have been consistently debated and discussed nationally.

As AP has developed in the twenty-first century, so have the number of AP roles and titles with repeated failure of attempts to regulate or protect the title in the UK. In 2005, the Nursing and Midwifery Council (NMC), which regulates all UK nurses, considered regulation of NPs; however, a subsequent government review by the Council for Healthcare Regulatory Excellence (CHRE) stated that all registered healthcare professionals had to comply with standards set by their professional body for professional practice and therefore a separate register/regulation was not required for NPs (Council for Healthcare Regulatory Excellence 2009). The CHRE suggested that employers must remain responsible for their healthcare work force by ensuring that NP practice meets their individual professional code of conduct. At the time of writing, governance is still employer led with the aim of maintaining quality and ensuring that appropriate standards are met to reduce any risk to patients and protect the public. Many nurse leaders have consistently pushed the NMC since 2005 to reconsider NP regulation leading to the NMC recently announcing that they are reviewing the regulation of NP roles due to multiple concerns regarding the lack of regulation (Mitchell 2019).

The UK's significant lack of regulation for NP and CNS roles has led to a plethora of titles utilized in clinical practice with no standardization. The RCN published guidance for NPs including scope of practice and educational standards (Royal College of Nursing 2012). A decision made to change the title, Advanced Nurse Practitioner, was made in 2012 (Royal College of Nursing 2012) in order to identify the "advanced" nature of the role. The title change was anticipated to bring more clarity to the role. However, a recent study by Leary et al. (2017) found 595 job titles in the UK which were being used in 17,960 specialist posts. Clinical Nurse Specialist, Nurse Specialist/Specialist Nurse, Advanced Nurse Practitioner and Nurse Practitioner were the most common. The nebulous and disparate use of titles in this way has led to concerns from clinicians, patients, policy makers and regulators leading to some attempts to standardize NP and AP practice in England (Health Education England 2017).

Working as an NP for over 20 years, I (Melanie) have had consistent concerns about the lack of title protection and regulation for advanced practice. I was involved in the early discussions with the NMC regarding NP regulation and have supported AAPE UK as they have lobbied the NMC to reconsider NP regulation. My work with the International Council of Nurses, Nurse Practitioner/Advanced Practice Nurse Network (ICN NP/APN) for 12 years has also enabled me to lobby for regulatory changes. As Chair of the ICN NP/APN Network for 3 years, I have been fortunate to support many countries developing AP roles. I have been saddened and have struggled with the UK being one of only two countries globally with established NP roles not to regulate the role. I have worked to support advanced practice globally through health policy, education, research and leadership. I have consistently spoken about the need for the UK to address this problem. Recently colleagues from the ICN NP/APN Network and the ICN clarified the definitions for advanced practice nurses, which will hopefully provide some direction for all countries developing advanced practice roles which have not yet been published. Some nurses in the UK tend to retreat from stepping up as leaders to promote and develop the profession. In order for nurses not to become overlooked as advanced practitioners, it is vital that nurses stand up and identify the value that advanced practice brings to patients and the healthcare system.

12.5 Royal College of Nursing (RCN) Leadership

The RCN ran the first NP programme in the UK in 1992. With the ongoing lack of regulation and title protection, the RCN became the national leader in developing practice competencies and educational standards for NPs. In 2002, the RCN produced its first guidance on the NP role to support the educational development of NPs at many universities across the UK. Initially, the title NP was utilized in the UK and supported by the RCN (2002). Due to regulatory issues, many nurses who had undertaken short courses in minor illness and minor injuries, for example, started to use the title, NP or Emergency NP. The RCN made the suggestion in 2012 that those working at an advanced level who

had achieved the educational and practice competencies use the title Advanced Nurse Practitioner (ANP) (Royal College of Nursing 2012).

In addition to the change of title to ANP, the RCN also has developed an accreditation process, which accredits university programmes that demonstrate compliance with the standards listed in Sect. 3 of their document (Royal College of Nursing 2008). Accredited programmes act as a national benchmark and identify that a graduate from an RCN accredited programme is educated at a national standard. This accreditation has not been significant in addressing some of the issues identified above regarding advanced practice standardization as many UK Universities have created their own independent programmes, which may or may not meet national standards leading to the further challenge for standardization of training. The lack of standardization of AP programmes brings significant leadership challenges. The role of AAPE and the RCN has been consistent to support standardization and ensure that programmes taught in the UK meet national standards.

The educational preparation of APs in the UK has moved towards masters level education as a requirement for advanced level practice. The RCN has been instrumental in ensuring that nurses who undertook NP educational preparation at graduate or diploma level should also be recognized as qualified NPs, as they may already possess a wide range of clinical experience and demonstrate advanced level practice. These nurses (and those who have a master's degree) can apply for formal credentialing through a robust assessment process run by the RCN. The RCN has provided an updated credentialing framework (Royal College of Nursing 2018a), which has been accepted by the health departments of all four countries with identified domains of advanced nursing and clinical practice. For credentialing, nurses must provide evidence of work across four pillars of advanced practice: clinical practice, leadership, research and education. This process developed in 2018 and is yet to be evaluated.

12.6 Government Leadership

England, as the largest country in the UK, has developed advanced practice in a different way from the rest of the UK. Health Education England (HEE), a government body, provides leadership and co-ordination for all healthcare education and training in England. HEE has been instrumental in the development of advanced practice education not just for nurses but also allied health professionals such as paramedics and pharmacists.

In England, advanced practice is viewed philosophically, as a level of practice, and expertise, or as a role with clearly defined competencies. HEE published their multi-professional framework for advanced clinical practice in England (Health Education England 2017), which reflects the move in England towards a level of practice with room for all health professionals to develop an advanced scope and boundaries of practice beyond their primary profession and specialty by masters level academic preparation (Health Education England 2017).

HEE's view that advanced practice is used to indicate a level of practice and not a specific role has been widely accepted by all four countries. However, Scotland,

Table 12.1 RCN NP educational standards

- Makes professionally autonomous decisions for which he or she is accountable
- Receives patients with undifferentiated and undiagnosed problems and makes an assessment of their healthcare needs, based on highly developed nursing knowledge and skills, including skills such as physical examination
- Screens patients for disease risk factors and early signs of illness
- Makes differential diagnosis using decision and problem-solving skills
- Develops with the patient an ongoing nursing care plan for health, with an emphasis on preventative measures
- Orders necessary investigations, and provides treatment and care both individually as part of a team and through referral to other agencies
- Has a supportive role in helping people to manage and live with illness
- Provides counselling and health education
- Has the authority to admit or discharge patients from their caseload, and refer patients to other healthcare providers as appropriate
- Works collaboratively with other healthcare professionals
- Provides a leadership and consultancy function as required

Wales and Northern Ireland recognize this level of practice to be only in the remit of NPs at this time. In England, other allied health professionals have pushed to get recognition of the value of their practice at this level leading to programmes of study now being multi-professional, with nurses still being the largest number. All programmes should align to national standards and typically follow the standard NP curricula seen in many countries with established NP roles. Completion of these programmes leads to the title, "Advanced Clinical Practitioner" (ACP) though many nurses who undertake these courses still use the title, "Advanced Nurse Practitioner" (ANP) as advocated by the Royal College of Nursing (2012, 2018b).

The HEE multi-professional framework has been a driving force towards the development of an Academy of Advancing Practice. The Academy will set national standards for advanced practice education and has included key leaders from advanced practice such as AAPE UK who are influencing the developments, in addition to discussions with the professional regulatory bodies. The aim of the academy will be to provide a governance structure for ACP education (Council of Deans of Health 2018). The academy will ensure quality assurance across England and provide strategic direction for the development of advanced practice. It is anticipated that the academy will provide university accreditation for ACP programmes and eventually accredit ACPs themselves, which at present will not be mandatory.

Key competencies of AP have previously been defined at the individual country level by commissioners in collaboration with employers, often reflecting the RCN NP educational standards (Royal College of Nursing 2002) (Table 12.1).

12.7 Health Policy Leadership

European policy, legislation and guidance regarding working hours reduced the availability of junior medical staff in many clinical areas such as emergency medicine leading to a rise in the development of advanced nursing roles to fill the gap

(National Health Service Management Executive 1991; European Economic Community 2000). Shortages of medical providers has also led to the other health professions considering how AP roles may benefit clinical practice leading to advanced clinical practitioner roles. Implementation of advanced roles has required changes to policy in the governance and regulation of professions in addition to financial and organizational support. Policy reforms around AP in the UK have been shaped by stakeholders, such as employers and clinicians, often in the medical profession. The role of healthcare managers has been key to support training and implementation of AP roles. The AP role has begun to change and influence workforce structures and cultures that now embrace and value the APs and other advanced practitioners.

Salaries for UK nurses working as APs are commonly paid by the healthcare organization in which they are employed. The salary model for financing uses existing health budgets to employ APs. In the UK, additional funding has been available from the governments in all four countries to support the costs of AP education and training, with some regions receiving financial support towards the individual salary whilst in training. Salaries are variable, as there is no protection of the role or title. APs working in primary care can generally negotiate a higher salary due to workforce shortages than those working in hospitals. Most APs are still paid at the top of the nursing pay scales but the CNS role often receives a lower salary. The AP role has been recognized as offering the potential to decrease health service costs particularly where medical shortages have resulted in high agency physician use. AP role expansion has led to innovative service redesign in some areas leading to cost savings, health improvements and increased patient satisfaction (McDonnell et al. 2015). Some innovations include AP-led primary healthcare services such as those in nursing homes; home visits and APs undertaking consultations in a geographical location where the elderly live rather than patients attending the surgery.

12.8 UK Country Developments Illustrating Leadership

As discussed previously, the four country developments within the UK are advancing at different paces. AP within England is currently being driven by HEE, with leadership support and advice being provided by AAPE UK and the RCN. The aim in England is advanced practice standardization, title protection and regulation, which will ensure advancement of the professions and public safety. The Academy for Advancing Practice is yet to be launched and should provide a structured process for recognition of practice with standards for both the individual and the educational institution where programmes are delivered.

Health Education and Innovation Wales (HEIW) has been established and is reviewing progress on advanced practice since publication of their framework. Some areas have well-established models. Notably HEIW representatives have now joined the English HEE ACP Steering Group and vice versa. This inter-country collaboration is seen as the beginning of working towards a UK wide advanced practice model as a long-term goal.

In Scotland, the three regional Academies of Advanced Practice are working to promote and support advanced practice. The Academies run continuous professional development events and maintain databases of advanced practitioners. Advanced Practice in relation to AHPs is progressing under the work from the NHS National Services Scotland 5 year plan which includes transformation of services, alongside what is already in place for nurses and paramedics. Central funding is being provided to increase numbers to meet patient need and service demands.

A new advanced practice framework was recently published for Northern Ireland with graduated levels of advanced practice including specialist, advanced level 1, advanced level 2 and consultant. An evaluation of their nursing framework for advanced practice is currently being undertaken with findings due to be published.

Below is a table that summarizes the commonalties and differences in the UK (Table 12.2).

UK definitions of advanced practice

Definitions of advanced practice:	
England	"Advanced clinical practice is delivered by experienced, registered health and care practitioners. It is a level of practice characterised by a high degree of autonomy and complex decision-making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, leadership and management, education and research, with demonstration of core capabilities and area specific clinical competence Advanced clinical practice embodies the ability to manage clinical care in partnership with individuals, families and carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes." (Health Education England 2017)
Scotland	"Advanced nurse practitioners (ANPs) are experienced and highly educated registered nurses who manage the complete clinical care of their patients, not focusing on any sole condition. ANPs have advanced level capability across the four pillars of practice: clinical practice, facilitation of learning, leadership, evidence, research and development. They also have additional clinical-practice skills appropriate to their role" (Chief Nurse Office Directorate (CNOD) 2016)
Wales	Advanced practice is "a role, requiring a registered practitioner to have acquired an expert knowledge base, complex decision-making skills and clinical competencies for expanded scope of practice, the characteristics of which are shaped by the context in which the individual practices. Demonstrable, relevant masters level education is recommended for entry level." (National Leadership and Innovation Agency for Healthcare 2010b)
Northern Ireland	An ANP in Northern Ireland "practices autonomously within his/her expanded scope of clinical practice, guided by The Code. Professional standards of practice and behaviour for nurses and midwives (Nursing and Midwifery Council 2018). The ANP demonstrates highly developed assessment, diagnostic, analytical and clinical judgement skills and the components of this level of practice" (Department of Health, Social Services and Public Safety 2016)

Table 12.2 UK advanced practice comparison

	England	Scotland	Wales	Northern Ireland
Advanced nurse practitioners	Yes	Yes	Yes	Yes
Clinical nurse specialists	Yes	Yes	Yes	Yes
Advanced clinical practitioners (commonly paramedics, pharmacists and physiotherapists)	Yes	Yes	Yes	No
Advanced practice framework	Multi-professional framework for advanced clinical practice (Health Education England 2017)	Advanced practice toolkit and framework for advanced nursing practice (Scottish Government Health Departments 2008)	Framework for advanced nursing, Midwifery and allied health professionals practice in Wales (National Leadership and Innovation Agency for Healthcare 2010a)	Advanced nursing practice framework (Department of Health, Social Services and Public Safety 2016)
Education standard	Masters Level	Masters Degree	Masters Degree	Masters Degree
Non-medical prescribing	Yes	Yes	Yes	Yes
Protected title	No	Yes—Advanced nurse practitioner	No	No
Regulated	No	No	Yes	No
RCN credentialing available for nurses working at an advanced level	Yes	Yes	Yes	Yes
Academy of Advanced Practice	One academy in development	Yes—three academies	No	No
Protected government funding	Yes, but reviewed by government annually	Yes	Yes	

12.9 Conclusion

Advanced practice in the United Kingdom as a whole has moved, or is moving, towards a multi-professional approach recognizing advanced practice as a level of practice rather than a specific role. Key to this level is the integration of the four pillars of advanced practice, clinical practice, leadership, education and research.

Specific challenges around regulation of advanced practice roles and title protection may change with the trend towards the development of Academies of Advanced Practice, which will provide governance for education and practice.

Successes of advanced practice leadership in the United Kingdom include the developments beyond nursing, encompassing advanced practice for allied health

professions also. The integration of advanced practitioners in all areas of healthcare with the ability of many of the professional groups to prescribe medicines independently has led to service improvements, increased access of services to patients as well as increased quality of care (McDonnell et al. 2015).

Leadership challenges of advanced practice in the United Kingdom are ongoing and include the need to urgently regulate the role, ensure standardization of educational programmes and provide title protection. An area of both challenge and opportunity includes leaders from medical colleges wanting to accredit advanced practice for their own specialties for example emergency care physicians offer NPs the opportunity to apply for the same accreditation as emergency physicians.

As we move forward leadership to develop Academies of Advanced Practice, we should ensure greater regulation and standardization in the form of credentialing and accreditation, which should increase transferability of skills and enable a more mobile workforce.

Leadership for advanced practice in the UK has included a combination of people in governmental bodies, the RCN and AAPE UK. Significant omissions by the NMC to regulate the role and title at its inception have caused many issues in the UK, which continue to impact advanced practice development. With a move towards allied health professionals becoming advanced practitioners, we have seen other bodies taking a lead in regulation and title protection. On reflection, in the UK the scope of advanced practice is one of the fullest internationally with full prescribing, referral and autonomous practice well established. The lessons we have learnt include the need for the nursing leadership voice to have been stronger and more coherent across the four countries.

For me, Melanie continuing to lead the ICN NP/APN Network has provided many opportunities for the UK to be more involved in the global developments of advanced practice. Being an NP is the most rewarding, challenging and stimulating role I have ever had. Being able to provide patients with holistic care, which brings together the best of nursing and the best of medicine, is a privilege. I am never bored and I am always honoured that patients are willing to share their deepest concerns with me and trust that I can make a difference to their lives through my holistic focus. In order to do this, it is paramount that regulation and title protection are established to protect patients and ensure the advancement of nursing.

Glossary

APN Advanced Practice Nurse
AP Advanced Practice
ACP Advanced Clinical Practitioner
AHP Allied Health Professional
ANP Advanced Nurse Practitioner
CNS Clinical Nurse Specialist
HEE Health Education England
NP Nurse Practitioner
RCN Royal College of Nursing

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Advanced Practice Nursing in the United States

13

Joyce M. Knestrick and Nancy Gentry Russell

In 1985, a small group of nurse practitioner (NP) visionaries and leaders met at a farm in Gettysburg, Pennsylvania to discuss the future of the NP role in the United States (U.S.). In order to ensure durability of the NP role, this group established a national organization to represent all NPs in the U.S., regardless of their area of specialty, which became known as the American Academy of Nurse Practitioners (the Academy) (American Association of Nurse Practitioners [AANP] 2019b). The mission of this organization was to provide a "voice" to the emerging NP role in the U.S., and represent all NPs in the U.S., which, at that time, numbered approximately 22,000–24,000 (Pulcini and Wagner 2002). By the end of its first year, the Academy had over 100 members (AANP 2019b). Today, the AANP, which represents over 270,000 NPs in the U.S. and boasts nearly 100,000 members, carries on the mission of the Academy by empowering NPs to advance quality healthcare through practice, education, advocacy, research, and leadership (AANP 2019b).

13.1 Early Work

Almost immediately upon its establishment, the Academy began taking action toward advocating for and advancing the practice of NPs in the U.S. In 1985, a national database was established to gather data regarding NPs and NP practice in the U.S. A year later, the organization began efforts to impact practice based on the data collected through this database, and in 1987, the U.S. federal government spent

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$100 million on NP education, paving the way for access to NP care (AANP 2019b). The Academy also recognized the need for increased information on the NP role, as well as information regarding malpractice and insurance practices for their NP members. As a result, the Academy conducted a survey to assist members with access to affordable malpractice insurance.

The Academy also worked to gather and disseminate evidence-based information regarding issues affecting NPs, including clinical practice, research, policy, and education. In 1989, the Academy launched its official journal entitled, the *Journal of the American Academy of Nurse Practitioners*, which is now the *Journal of the American Association of Nurse Practitioners*. The Academy also hosted its first National Conference with 158 attendees in 1989. Additionally, the organization began to collect data on NP preparation and practice characteristics (Towers 1989a, b, c; Towers 1990). The survey was repeated in 1999, and analysis of the two surveys demonstrated a growth of the NP role. Studies on NP practice found the primary care provided by NPs to be cost-effective and of high quality (Brown and Grimes 1995; Horrocks et al. 2002). To support further research concerning NPs and NP practice, the Academy formed the Network for Research (AANPNR), a national practice-based research network for NPs, in 2002.

In just 15 years since the inception of the Academy, the number of NPs in the U.S. had increased to approximately 82,000 (AANP 2019b). By 2010, the Academy celebrated 25 years as an organization and had approximately 28,000 individual members representing 140,000 NPs in the U.S. (AANP 2019b). Since the early beginning of the Academy's advocacy, significant legislative changes have been made to propel the NP role. In the 1990s, reimbursement for services provided by NPs was paramount to the organization, as NPs could previously provide services for federal government employees but were not able to be paid for those services (AANP 2019b). The Academy worked to ensure that NPs were recognized by the Federal Employee Health Insurance as providers and were able to be directly reimbursed for their services. Another early leap for NP practice was the implementation of national legislation to provide direct payment to NPs caring for rural patients receiving Medicare, a federal health insurance program for people 65 years of age and older, with disabilities and with End-Stage Renal Disease. The groundbreaking legislation known as the Balanced Budget Act of 1997, which became Public Law 105-33, recognized NPs as Medicare providers and allowed them to receive payment for all eligible services under Medicare. This legislation also enabled the Academy to work with states to recognize NPs under Medicaid (joint state and federal programs that provide health coverage to eligible low-income patients) and by private insurance panels.

13.2 The Merger

Despite the growth of the Academy and the many gains for NP practice made by this organization, due to philosophical differences, in 1995 another NP organization was created: the American College of Nurse Practitioners (ACNP) (AANP

2019b). Over the next couple of decades, the two groups often addressed the same issues regarding NP practice, and despite collaborating on issues, conflicts arose as to which organization was the primary voice for the profession. To solidify the voice of the NP in the U.S., the Academy merged with the ACNP in 2013, creating the largest national professional membership organization of NPs of all specialties (AANP 2019b). The merger of the two associations resulted in the development of the American Association of Nurse Practitioners (AANP) and created a unified voice for NPs in the U.S. to network and advocate for issues impacting NP practice. By 2014, the AANP had over 50,000 members and represented over 171,000 NPs (AANP 2019b). The impact of the merger had a positive effect on the ability to speak with one voice in the areas of practice, education, advocacy, research, and leadership. In addition, the merger empowered AANP and the NP community at large to shape policy, impact legislative priorities, gather research on practice issues, and operate from a position of unity and visibility-one "Voice of the NP" (AANP 2019b).

13.3 The American Association of Nurse Practitioners

Since the merger in 2013, the AANP has provided leadership to the NP community and has worked to forge coalitions with other nursing and advanced practice groups. At this writing, the AANP has close to 100,000 members, representing over 270,000 NPs in the U.S. (AANP 2019b). Providing leadership as an organization is the quintessential purpose for the AANP. Following the principles of leadership, the AANP strives to provide NPs with the tools to perform to their maximum potential, including practice standards, continuing education opportunities, advocacy at the federal and state levels, research on the NP role, practice, and a program to develop NPs as leaders in the U.S. healthcare system (Drucker 1992). The AANP has also launched a national campaign, focusing on patients who choose NPs as their healthcare provider of choice, to highlight the unique role of the NP and the quality and cost-effective care they provide (AANP n.d.; VanBuege 2017; Xue et al. 2016; Zwilling and Owens 2018).

13.4 Collaboration with Nursing and Other Organizations

Kindgon (1995) proposes that three streams run through the political system: a problem stream, a policy or solution stream, and a political stream. Distinct organizations often have similar concerns related to the problem stream, where problems that should be addressed are identified. Working in collaboration on an issue of concern to multiple groups helps with the policy or solution stream, which in turn provides a mechanism to address the issues and impact the political stream. In the U.S., the political stream may be public opinion or Congress. Lober (1997) added a fourth stream to Kingdon's work: an organizational stream. This stream considers changes in the organizational or industry

behavior regarding an issue being addressed. According to Lober (1997), when the streams converge, a window for collaboration is formed.

At the national level, the changes in healthcare and policy can lead to opportunities for collaboration among nursing and other healthcare-related organizations. In order to establish grassroots efforts in moving the NP agenda forward, the AANP frequently works collaboratively with these organizations to impact change. In the U.S., multiple national nursing organizations exist (see Table 13.1). Others include the National

Table 13.1 Selected nursing leadership groups in the United States

Nursing leadership group	Representation in nursing	Leadership contributions
American Association of Nurse Practitioners (AANP) (AANP 2019a)	Nurse Practitioners (NP)	• Advance practice of NPs at the local, state, and federal levels
	~270,000 licensed NPs in the U.S.	• Certifies NP practice
	>99,000 are AANP members	• Position statements
		• Publications
American Nurses Association (ANA) (ANA n.d.)	Registered Nurses (RN)	• Advance nursing profession for all RNs in the U.S. at the local, state, and federal levels
	~4 million RNs in the U.S.	• Three subsidiary organizations:
	ANA members are in all 50 states and U.S. territories (54 constituent member associations)	– American Academy of Nursing
		– American Nurses Foundation
		– American Nurses Credentialing Center
		• Position Statements
		• Publications
American Academy of Nursing (AAN) (AAN 2015)	Distinguished Nursing Leaders	• Affiliate of the ANA
	Its 27,000 members are known as Fellows of the American Academy of Nursing (FAAN)	• Advances the knowledge, education, and practice of nursing through multiple policy and research initiatives, expert panels, and programs to support future nurse leaders
		• Publications
American Association of Nurse Anesthetists (AANA) (AANA 2019)	Nurse Anesthetists (CRNA)	• Advance practice of CRNAs at the state and federal levels
	~90% (53,000) of CRNAs in the U.S. are AANA members	• Promotes CRNA education standards and guidelines
		• Certifies CRNA education and practice
		• Position statements
		• Publications
National Association of Clinical Nurse Specialists (NACNS) (NACNS 2019a, b)	Clinical Nurse Specialists (CNS)	• Advance practice and education of CNS nationwide
	~70,000 CNS in the U.S., 2000 of which are NACNS members	• Position statements
		• Publications

Table 13.1 (continued)

Nursing leadership group	Representation in nursing	Leadership contributions
American Association of Critical-Care Nurses (AACN) (AACN 2019)	Critical-Care Nurses	• Promotes excellence of critical care nursing practice nationwide
	World's largest specialty nursing organization	• Collaborates with other nursing, physician, and healthcare organizations to advance major health policy issues
	100,000 members	• Certifies critical care nursing practice
	More than 200 chapters nationwide	• Publications
American College of Nurse-Midwives (ACNM) (ACNM 2017)	Certified Nurse Midwives (CNM) and Certified Midwives (CM)	• Support midwives and advance practice of midwifery nationwide through the promotion of education, research, and advocacy at the state and federal levels
	Oldest women's healthcare organization in the U.S.	• Global health focus through membership with the International Confederation of Midwives (ICM)
	More than 11,000 CNMs and 97 CMs in the U.S.	• Publications
	More than 6500 members	

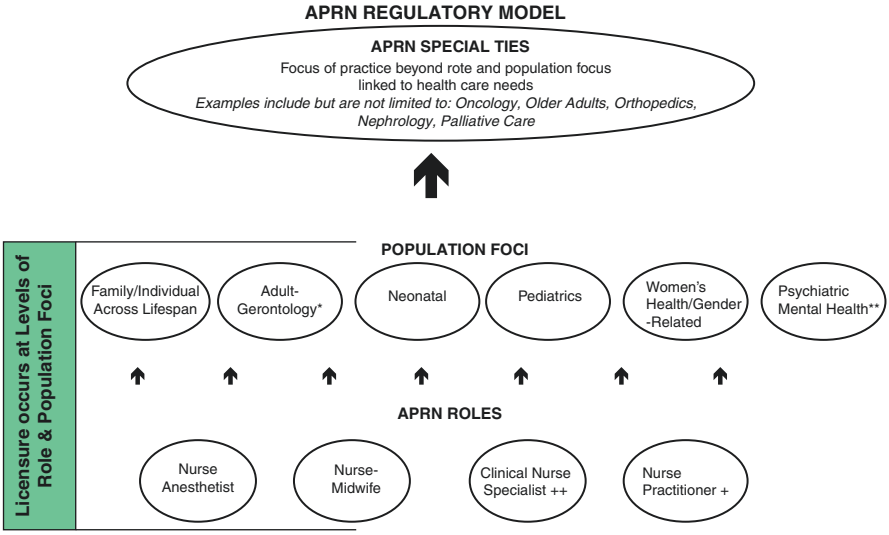
Association of Pediatric Nurse Practitioners (NAPNAP), the Gerontological Advanced Practice Nurses (GAPNA), the National Association of Women's Health Nurse Practitioners (WHNP), and the National Association of Nurse Practitioner Faculties (NONPF). In addition, various advanced practice groups exist in individual states. Working together has brought a solid voice for change in NP practice.

A prime exemplar of the AANP's leadership and collaboration that positively impacted the role of the NP is the APRN Consensus Model, which was developed to outline the regulatory requirements in licensure, accreditation, certification, and education (LACE) at the state level for all NPs. An NP Roundtable was formed to identify issues common to NP groups and formulate position statements to be used to inform policy and legislation. Another example is the collaboration by the nursing coalition to make permanent the ability of APRNS to prescribe medication-assisted treatments (MATs) for patients suffering from opioid addiction.

13.4.1 Consensus Model

In 2008, a group of 24 U.S. nursing organizations and The National Council of State Boards of Nursing Advanced Practice Registered Nurse (APRN) Advisory Committee came together to discuss the development of a uniform model of regulation across the U.S., as the lack of a uniform model of regulation of APRNs across the states created barriers to NP practice and affected patient access to healthcare. As a result of this collaboration, the APRN *Consensus Model* was born (NCBSN, 2008a; Mack 2018) (see Fig. 13.1).

The *Consensus Model* recognized APRNs as key providers of high-quality, cost-effective, and accessible healthcare in the U.S. The group identified four APRN



+The certified nurse practitioner (CNP) is prepared with the acute care CNP cornpetencies and/or the primary care CNP competencies. At this point in time the acute care and primary care CNP delineation applies only to the pediatric and adult-gerontology CNP population foci. Scope of practice of the primary care or acute care CNP is **not setting specific** but is based on patient care needs. Programs may prepare individuals across both the primary care and acute care CNP competencies. If programs prepare graduates across both sets of roles. The graduate must be prepared with the consensus-based competencies for both roles and must successfully obtain certification in both the acute and the primary care CNP roles. CNP certification in the acute care or primary care roles must match the educational preparation for CNPs in these roles.

Fig. 13.1 APRN regulatory model. (With permissions from NCSBN)

roles: certified nurse anesthetist (CRNA), certified nurse-midwife (CNM), clinical nurse specialist (CNS), and certified nurse practitioner (CNP). According to the *Consensus Model*, an APRN chooses a role, and education focuses on at least one of six population foci: family/individual across the life span, adult-gerontology, pediatrics, neonatal, women's health/gender related, or psych/mental health. The *Consensus Model* also established guidelines for APRN education to include graduate courses in advanced physiology/pathophysiology, advanced pharmacology, and advanced health assessment (NCSBM 2008). In addition, an APRN regulatory model was developed to standardize the **L**icensure (the granting of authority), **A**ccreditation (formal review and approval of education programs), **C**ertification (formal recognition of the knowledge and skill, and experience by meeting standards set by the profession), and **E**ducation (the formal preparation of the APRN in graduate degree or postgraduate certificate programs) of the four APRN roles previously described (NCSBN 2008a).

The *Consensus Model* aims to improve the ability of APRNs to practice to the full extent of their training and licensure and promote greater mobility of APRNs nationwide, all of which will improve patient access to quality care by APRNs (Mack 2018). Since its development over a decade ago, the *Consensus*

Model has become the standard regulatory model for APRN education and practice in the U.S. Over 40 professional nursing organizations have endorsed the *Consensus Model*, and 23 states have implemented the *Consensus Model* (Mack 2018).

The AANP became involved early in the process of the development of the *Consensus Model* and brought the voice of the nurse practitioner to the table. At that time, the AANP provided national certification for NP practice and therefore offered both the experience of the practicing NP and information regarding certification. Additionally, the data that ANNP was able to provide from their sample surveys of NP practice, as well as data related to certification, provided a picture for the group on a regulation model for NPs, which was in line with the model for all APRNs.

13.4.2 NP Roundtable

An NP Roundtable was developed in 2008 to facilitate a united voice regarding NP practice and included the GAPNA, the NAPNAP, the NPWH, the NONPF, and the AANP (AANP 2019c). The AANP provided leadership for this group by helping to identify shared positions and policy statements among the groups and developing a unified message for policy-makers and the healthcare community at large about issues impacting NP practice (AANP 2019b). Examples of joint statements the roundtable released included topics such as The NP Perspective on Education and Post-Graduate Training, The NP Perspective on Health Care Payment, and The NP Perspective on Health Care Reform (AANP 2019c). The joint statements and collaboration of the roundtable members continue to advance the policy agenda and coordinate advocacy efforts on behalf of NPs (AANP 2019b).

13.4.3 Medication-Assisted Treatment (MAT) for Opioid Disorder

Another example of the collaboration between AANP and other nursing organizations to lead change in the U.S. policy was the recent work of the nursing organization coalition (led by the AANP) to expand the 5-year wavier for NPs to prescribe MAT for patients with opioid abuse disorders and make that wavier permanent. In addition, the group worked together to expand the ability to prescribe MATs to CRNAs and CNMs. After the AANP and other nursing organizations provided several briefings and testimony before Congress, legislation to expand the ability to prescribe MATs was passed by both the U.S. House and Senate and signed into law by President Trump in October 2018. Increasing MAT prescribers, including NPs, provides greater access to treatment and hope for recovery for those who suffer from addiction to opioids.

13.5 States and State NP Organizations

As a national organization, the AANP sets the national standards for NP practice. In the U.S., state organizations may also join the AANP as an NP Organization (NPO) member. The AANP offers benefits to the NPOs including an AANP membership, continuing education, advocacy services and research opportunities. Each state has unique opportunities and challenges, particularly in the advocacy arena. Currently, in 22 states, the District of Columbia, and two territories, NPs can practice to their full scope of training and practice without the supervision from or collaboration with another profession. Of the remaining states, some are close to full-practice authority for NPs, while other states are very far. The elimination of barriers to full-scope NP practice creates greater access to care, particularly for those in rural, vulnerable, and underserved areas in the U.S. (VanBuege 2017).

13.6 Conclusion

From humble beginnings, the AANP (formerly the Academy and the ACNP) has continued to move forward to be the "voice" of the nurse practitioner. The AANP continues to grow in membership, offer services related to practice, continuing education, advocacy, research and leadership, and seek opportunities to make changes in the healthcare system. The impact of AANP and the voice of the NP is essential in the U.S. NPs continue to be the change agent for reform in the U.S. health system by providing patients with high-quality, cost-effective care.

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Part IV

Academic APN Leadership

Crucial cornerstones of knowledge needed to educate highly qualified nurse practitioners are discussed in the first chapter. These cornerstones include a focus on the role of the nurse practitioner, the education and testing of students, and requirements imposed on academics in education and the quality system. The chapter describes the intrinsic motivation of academics and lays out the challenges in this role. These cornerstones should increase accountability, ownership, and involvement in decision-making in students. A supportive learning environment, as well as coaching and empowerment by means of servant leadership are necessary cornerstones to graduate highly qualified APNs.

The second chapter focuses on the educator as a source of leadership development for students in APN programs and on the challenges of being an academic leader. Content relevant to leadership understanding and skills development is presented. The challenges of integrating scholarly activity into a clinical curriculum which foster a lifelong commitment to adding new knowledge are considered. Building alliances with clinical partners, other academic institutions, and professional organizations to enhance the educational experience are explored.

The final chapter provides an example of strengthening nursing leadership and practice in Sub-Saharan Africa. This program was developed in response to a growing burden of disease in the face of a critical shortage of health workers. A program representing the collaboration between the Global Health Service Partnership educators and Eswatini nursing faculty to develop and implement an FNP curriculum and role is described.

Leadership in Maintaining Standards for the APN Role

14

Jeroen W. B. Peters and Petrie F. Roodbol

The academy for Advanced Practice Nursing (APN) is tasked with training highly qualified nurse practitioners (NP) who are ready for lifelong learning. How is this achieved? In the first instance, the development of documents with views of (1) the role of the NP, (2) education and testing, (3) the requirements imposed on academics, and (4) the quality system seem to be the most crucial cornerstones. However, in practice we see that extra cornerstones should be added which ultimately involve the work of academics and practice leaders to implement. We, therefore, need to create these extra cornerstones in order to guarantee that professionals are enabled and challenged to function optimally. This requires a culture change in academia where intrinsically motivated choices are made. For this aim, implementation of collective ambition, shared values, and a supportive learning environment should considered as important as the development of documents.

14.1 The Why: Vision Development

At the basis of a curriculum is the professional competency profile, which describes the domain, the scope of the profession, and the competencies. In addition to the professional profile, standard literature on the APN and research on cost-effectiveness and efficiency can be used to develop a vision statement for a curriculum. When drafting this statement, it is important to start with the end in mind; what do you

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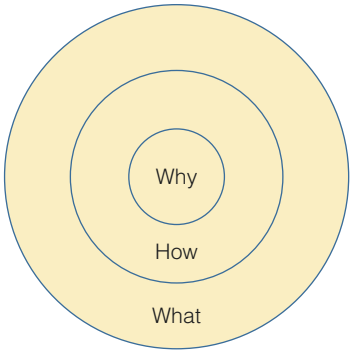

Fig. 14.1 Golden Circles Simon Sinek (2013)

really want to obtain with your program. The Golden Circles of Simon Sinek (2011) can be very helpful with this task. This is a simple but powerful model that maps out the "why," "how," and "what" an organization needs to distinguish itself. Initially, this model was developed for the business community, but it is applicable in academia as well (Fig. 14.1).

- The "why" stands for the objective, the driving force or the belief of an organization; why do you exist and why does it matter to others?
- The how stands for how do you want to distinguish yourself in the market and what are the unique selling points?
- The what stands for what do you deliver?

Most organizations and also academies first define the "what" and then the "how" and only then think about the "why." This is known as the "outside in" method. An APN program that thinks from the perspective of the "what" point of view conveys only that they train NP. It does not mention the qualities such as competence and leadership. According to Sinek, this method is not very effective. He says "people don't buy what you do, they buy why you do it, and if you talk about what you believe, you will attract those who believe in what you believe." Research by Sinek shows that inspiring and successful organizations start with the "why," then think about the "how" and ultimately the "what." This is known as the "inside out" method. He argues that the vision should be leading and only then should you decide how you want to do something and what priorities you set in this respect.

The "why" is more decisive than is often thought. If, for example, the "why" is defined as: thanks to the efforts of NPs, healthcare will remain accessible and affordable in the coming decades, the current paradigm—i.e., the biomedical model—will remain central. It remains to be seen whether everyone is enthusiastic about this direction. If the "why" is defined as: all patients must have and maintain control over their own health and thus, thanks to the efforts of NPs, healthcare is kept accessible and affordable, then the roles of NPs are seen as an addition to the current biomedical approach in healthcare. The vision, the why, can thus determine the role of the NP within healthcare.

14.2 The How: Defining the Unique Selling Points

The "why" should then be translated into the "how" in order to establish the academic cornerstones necessary for NP education, like vision of (1) the role of the APN, (2) education, (3) assessment, (4) quality assurance system, but also (5) organization and academic culture cornerstones.

14.2.1 Cornerstone: Vision of the Role of the APN

The professional competency profiles, developed by the national NP associations in collaboration with social partners, describe the role of the NPs in clinical practice. The curriculum determines how the required competencies should be taught. In this respect, it is important that the academy convey the nursing paradigm by which the students are trained.

The content of a paradigm is not a fixed fact, rather an evolving step by step process as the paradigm shifts. Paradigm shifts have taken place in nursing, but the core paradigm of nursing does not seem to have changed fundamentally since Virginia Henderson (1960). She states, "The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible, or to assist in dying peacefully when recovery is not possible."

To cover all human needs, Henderson developed the holistic Need Theory that consists of 14 components of human functioning divided in to physiological, psychological, spiritual, and social needs. By means of this theory, nurses added an extra dimension to the care physicians provided. More recently, Henderson's focus on healthcare is also picked up by the WHO, which in 2001 developed the International Classification of Functioning, Disability, and Health (ICF) (WHO, 2007). This system was developed to promote interprofessional collaboration. The central paradigm is human functioning, i.e., how people function in their daily lives and on what they need in order to be able to function in the presence of disease (Bickenbach et al. 2012). Health is defined as "the ability to adapt and self-manage in the face of social, physical, and emotional challenges." This definition, like Henderson's, strongly emphasizes "the ability to adapt," including focusing on how to stay healthy, rather than only focusing on causes of disease.

14.2.2 Cornerstone: Vision of Education

Paradigms can also be distinguished in education. In view of the theme of this chapter, we will confine ourselves to APN education, which in many countries combines adult education with practice-oriented learning. The apprenticeship model is often used in the context of workplace learning.

Theories of adult education can be divided into, or related to, several categories: (1) instrumental learning theories, (2) humanistic theories, (3) transformative

learning theories, (4) social theories of learning, (5) motivational models, and (6) reflective models. Each academic should decide which learning theory they integrate into their curriculum. The question one should ask is which learning theory and principles are the most useful to your APN curriculum, but also which of these learning theories facilitate deep learning effectively?

Taylor and Hamdy (2013) introduced a model that encapsulated these learning theories to help structure, plan, and deliver successful learning experiences. They proposed five stages in the learning experience, including specific roles for teachers and students (see Table 14.1):

Table 14.1 Adult learning model in action (Taylor and Hamdy 2013)

Phase	Student's roles	Teacher's roles
Dissonance phase	• Identify prior (base-line) knowledge, skills, and attitudes • Recognize what is unknown • Recognize personal development and learning needs • Participate in planning personal learning objectives and relevant experiences	• Provide the context in which the student can learn • Increase extrinsic motivation through appropriate tasks • Help learner to recognize or promote internal motivation factors • Explore the learner's prior knowledge and experiences • Help student to identify his/her learning needs and the relevance of each
Refinement phase	• Think of many possible explanations or solutions to the case or problem • Work out which are the most likely resources to refine the possibilities • Actively participate in the activity and experiences • Refine the information into a hypothesis	• Ensure the relevant learning experiences are available at the appropriate level for the learner
Organization phase	• Test and re-test the hypothesis • Organize the information into a "story" that makes sense to the learner	• Provide advance organizers for the learners—structures upon which they can continue to build • Encourage reflection in action
Feedback phase	• Articulate the knowledge, skills, or attitudes developed • Provide feedback to peers and staff • Accept, and if appropriate act upon feedback received from others	• Reflection on the learning experience (in action and on action) • Provide feedback to the learner, formally or informally • Accept, and if appropriate act upon feedback received from the learner
Consolidation phase	• Reflection in the light of prior knowledge • Reflection on the learning process • Evaluate personal responsibility for the learning • Development of knowledge, skills, and attitudes	• Provide opportunities for the learner to rehearse and/or apply their new knowledge • Encourage reflection on action

1. Dissonance
2. Refinement
3. Organization
4. Feedback
5. Consolidation

In addition to thinking about the educational vision, it is also important to think about the methods used to stimulate deep learning. This could include empowering students by having them ask good questions, learn to use analogies and concept mapping, participate in peer teaching, have them think and contemplate critically, make use of reflection, use the right learning materials, ask for feedback, apply new knowledge and skills in new situations, make use of simulations, and learn from doing (Azer et al. 2013). Also, one should not offer too much new knowledge at the same time because of the limited processing capacity of the brain (Young et al. 2014), i.e., our brain is limited to store seven new pieces of information at the time.

14.2.3 Cornerstone: Vision on Assessment

Within education, many times academics do not take proper time to develop assessments and thereby going beyond the fact that assessments should be reliable and valid, and that proper developed tests can also provoke learning. To guarantee the basic quality of tests, an academic has to devise a testing program consisting of four different phases, which cannot be seen in isolation:

1. Assessment policy: Indicates the institution's vision on assessment; why it is done, who is involved, when are the assessments administered, what is being assessed, and how assessments are designed.
2. Assessment program: a carefully composed combination of assessments fits with the goals, content, and structure of the curriculum.
3. Assessment instruments: Each assessment must meet the criteria of usability, reliability, and validity.
4. Assessment tasks: The assignments, tasks, or items on which the students are assessed. These must be relevant, objective, and distinctive, and the degree of difficulty must be appropriate to the level being assessed.

In each phase, evidence should be used to reflect on the requirements that have been set for this. Regarding the phase "assessment policy," the question is how we want to transition the student from novice to expert? This transition is characterized by an increase in the aggregation of concepts from isolated facts, through semantic networks to illness scripts and instance scripts. The latter two stages enable the expert to recognize the problem quickly and form a quick and accurate representation of the problem in his/her working memory. Striking differences between experts and novices is not per se the possession of more explicit knowledge, but the superior organization of knowledge in his/her brain and pairing it with multiple real experiences, enabling not only better problem-solving but also more efficient problem-solving

(Benner, 1982). And how do we want to achieve this? Via assessment of learning, assessment for learning, or both? Which methods are used for assessing parts of the theoretical program, and which are used for work-based assessment?

In addition, choices can be made for fully summative assessments, formative assessments such as programmatic assessments (Schuwirth and van der Vleuten 2011a, Schuwirth and Van der Vleuten 2011b), or a mix of the two. Consideration should be given to whether a summative assessment sufficiently facilitates and challenges learning. Choices made in the testing policy have an influence on the students' learning and possibly even on their performance. In addition to the above questions, academics should also take into account assessment bias, such as the primacy, recency, and HALO effects (Schuwirth and van der Vleuten 2011a, Schuwirth and Van der Vleuten 2011b). Finally, it is necessary to consider, possibly by means of research, which mix of tests actually give a reliable picture of a student's knowledge, skills, and attitude (Moonen-van Loon et al. 2013).

14.2.4 Cornerstone: Quality Assurance and Quality Assurance System

Quality assurance can be introduced from two perspectives: quality assurance systems that are initiated by the academy, and initiated by the student.

In the case of quality assurance systems initiated by the academy, this could include the development of a long-term quality plan. The visions and ambitions of the program form the basis of this quality plan. It also describes the improvements that need to be implemented, the quality measuring instruments that will be used, and the standards used in this respect. Academics often limit themselves to students' grades, drop-out rates, student evaluations, and periodic audits and reviews. It is important to periodically complete the Plan Do Check Act circle and adjust the plan and the goals on the basis of the outcomes. What can be even more effective is to take into account research findings from literature or from your own line of research.

A quality care system from the student's perspective could be a system in which a student forms his or her own quality system, in which reflection, learning, and improvement are driven by an intrinsic motivation and in which students do not hunt for credits, but for feedback (see Sect. 14.3.3). Students then see this feedback as an opportunity to further improve competencies.

14.3 Organizational and Cultural Cornerstones

It is one thing to put visions on paper, but another to make sure that they are implemented properly. When elaboration on Sinek's "how," we should also give an answer on: how can these cornerstones, i.e., all intentions, visions, and systems that are on paper, be implemented in the behavior of academics so that this is also reflected in: (1) providing lessons, coaching, and guidance to students, and in (2) maintaining and improving the quality of education?

From our daily lives we know that having good intentions does not always lead to new behavior. Also, rules that are imposed from above, except when fear reigns, are often not followed. Behavior is more difficult to influence than is thought; this requires a change of culture that particularly stimulates the intrinsic motivation of the academics. High intrinsic motivation leads to better performance and a better response to changes. To stimulate this form of motivation, we need to establish a culture with a collective ambition, shared values, inspiration and working together from a learning environment, in which the demand for competence, relatedness, and autonomy is met (Deci and Ryan 2008). But, what are the building blocks of such a culture?

14.3.1 The Academic Working Environment

An academy consists of highly educated motivated academics who strive for autonomy, control over their own work, and for the democratic and dialogical solving of problems and setting up work processes. This form of organization, described by Mintzberg (1993) as professional bureaucracy, differs fundamentally from a machine bureaucracy. The professional bureaucracy is complex because it involves, on the one hand, many rules and procedures developed by management and staff, and, on the other hand, academics who do not want to be bothered by the planning and control of their work processes, which they often experience as a hindrance (Weggemans, 2014). The need of academics for a democratic and organic way of working is diametrically opposed to the need of managers and staff members for control by drawing up rules and procedures. An explanation for this need for control is often a lack of trust in the involvement and self-management capacity of academics, whereas academics can be described as highly intrinsically motivated with a high self-management capacity (Adler and Kwon 2013; Weggemans, 2014). While a machine bureaucracy (Mintzberg 1993) can function optimally with vertical control systems, i.e. with rules that are imposed from above, this leads to conflicts among academics because academics work from horizontal control systems. Weggemans (2014) shows that if academics feel hindered by these vertical rules and procedures, they protest less and less against them and simply play the game. This ultimately takes less energy than being against and protesting; the management is served with information, but the academics do not see that information as leading for their work. By applying this strategy, academics go their own way. According to Weggemans, this behavior can be described as "struggling with." One reason for this is the lack of shared ambitions within the organizations.

If the organization is able to maximize the affective bonding of academics, and thus the congruence between their personal goals and those of the organization, then the energy level of academics will also increase, as will their inclination towards internal entrepreneurship. So, the more collective the ambition, the more the number of shared values, the greater the intrinsic motivation, the higher the energy level, the less planning and control is needed and thus the smaller the chance of "struggling along." It is therefore up to the team leader to ensure that the team members

suffer as little as possible from the vertical control systems and can continue to do their work on the basis of their expertise and autonomy.

Leaders of teams in professional organizations should also have the following competencies: (Weggemans, 2014)

1. Develop a collective ambition based on participation, so that it is supported
2. Stimulate cross-border cooperation on the basis of multiform structures
3. Direct colleagues on output and not on process; personal and commitment statements can be helpful in this
4. Inspire colleagues
5. Stimulate and challenge colleagues' curiosity to learn, so that they remain involved in their profession in accordance with the state of the art
6. Be there for colleagues, observe well, and be able to communicate by listening attentively and asking questions
7. Dare to differentiate between colleagues and dare to act assertively towards colleagues who are no longer as good at their profession
8. Function as a heat shield for "noise from above"
9. Provide guidance from an authoritative but serving attitude

These competencies can be complemented by working with leading coalitions in the event of problems. The boss does not always have the best solution to a problem. Focus first on who, then what. Leaders need the support of a group of enthusiastic people across the entire organization.

14.3.2 Cornerstone: Professional Governance

Professional governance is a form of organization that offers a solution to the limitations of professional bureaucracy and that is in line with the advice given in the previous section. Within this form of organization, particular emphasis is placed on horizontal rather than vertical control systems and on the autonomy of academics (Swihart and Porter-O'Grady 2006). In this model, the power of decision-making is largely vested in academics (Porter-O'Grady, 2019). This way of working seems to increase empowerment, confidence, and higher job satisfaction among academics (Hastings et al. 2014).

Shared governance is defined as shared decision-making based on the principles of partnership, equity, accountability, and ownership at the point of service. This management model empowers all members of the healthcare workforce to have a voice in decision-making, thus encouraging diverse and creative input that will help advance the business and healthcare missions of the organization. In essence, it makes every employee feel like he or she is "part manager" with a personal stake in the success of the organization (Swihart and Porter-O'Grady 2006). Shared governance is based on four principles (Swihart and Porter-O'Grady 2006):

1. Partnership: essential to building relationships and involves all team members in decisions and processes, it implies that each member has a key role in fulfilling

Table 14.2 Difference between accountability versus responsibility (Porter-O'Grady, 2019)

Accountability	Responsibility
Outcome-defined	Relates to functions
Self-described	Delegated by another
Embedded in roles	Dictates specific routine
Relies on partnership	Isolates work and staff
Evaluation is shared	Evaluated by supervisor
Value in contributions	Tasks determine value

the mission and purpose of the organization, and is critical to the system's effectiveness.

2. Equity: that each team member is essential to providing safe and effective training of the students.
3. Accountability: the core of shared governance and requires a willingness to invest in decision-making and express ownership in those decisions. Accountability is often used interchangeably with responsibility, although both differ, see Table 14.2.
4. Ownership: shared governances requires all team members to commit to contributing something, to own what they contribute, and to participate in devising purposes for the work.

Professional governance should not be seen as a management strategy or a management trick just by placing many decisions powers lower in the organization. Directors and managers need to develop competencies so that they can position academics in different ways. They also should be aware that academics have been trained to govern themselves in the interest of those they serve, as evidenced by standards for generating and implementing knowledge, education, practice, indicators of quality/impact, competence requirements, ethics, disciplinary processes, and professional behavior. And the challenge for them is how to coach and guide these academics so that they will meet the organizational requirements imposed on them by the board, management, and staff (see Sect. 14.3.4).

14.3.3 Cornerstone: Team Functioning and Community of Practice

Professional governance does not mean that every academic can do his or her own "thing." To prepare highly educated NPs, cooperation and coordination within the team in which the cornerstones (see Sects. 14.2.1–14.2.4) are jointly developed, propagated, and adjusted is important. For this to be effective, each team member must work towards being a role model, and each role model should work, supervise, and coach on the basis of the same cornerstones. By placing more emphasis on relational structures at group level, rather than at individual level, the effectiveness of the organization can be further improved (Horwitz and Horwitz 2007). And if this is facilitated by a learning culture within the team, personal growth and development can be stimulated.

A model that stimulates the establishment of relationships and continued learning is that of the community of practice. This model has its roots in the social constructivist vision of learning. Initially, this model was developed to (1) promote learning and develop the professional identity within communities from a socially constructivist point of view (Andrew, 2012) and (2) to enable healthcare professionals who switch to the academy to develop their new identity (Woods et al. 2016). In addition, this body of thought seems to be very suitable for making and keeping teams of academics accountable and self-directed.

A community of practice is formed by a group of academics who, out of a common interest, have the need to deepen their knowledge originally and expertise on a certain theme and who find it useful to learn from, with and to each other in a socially constructivist manner. The group is the guiding principle in realizing cooperation, in which the members enter into dynamic and committed relationships with each other and/or with others (Woods et al. 2016). Committed in this context should be understood as these academics are both physically (acting) and cognitively (thoughts/conceptions) and emotionally (instinctively) fully connected to their work roles. They throw themselves into their work with dedication and give just that little bit extra (Smith et al. 2017).

Within the community of practice, the aim is to create a good team climate that provokes and facilitates learning. But to be successful, team members must also be able to complement each other, counterbalance each other, and dare to give each other feedback. A good balance between the different points of view in the team forces team members to profile themselves and get the best out of themselves. Research by Horwitz and Horwitz (2007) shows that task-related diversity (e.g., functional expertise, training, and organizational ambitions) has a positive effect on team performance. On the other hand, demographic variables of team members (e.g., age, gender, background) do not.

From the community of practice, we can actually draw a parallel to the learning environment of students. After all, for a learning culture, a culture of feedback and reflection is a necessity. In light of the ideas of the community of practice, academics can be expected to continue to learn on the basis of the social constructivist learning vision, just like students. The feedback model of Hattie and Timperley (2007) fits in well with this form of participatory learning. Academics, but also students, develop faster and more effectively when it is clear to them how they perform and what they should do to reach the desired level. To achieve this, feedback should focus on three feedback questions and four feedback levels.

These feedback questions relate to:

1. Feedup: which goal or results do you want to achieve?
2. Feedback: how did you perform the task so far?
3. Feedforward: what do you still have to do to achieve the set goals?

Answering the feedforward question is perhaps the most important thing in order to fill the gap between where you stand and the goal to be achieved (Hattie

and Timperley 2007). Next to the three feedback questions, the level at which the feedback focuses is important for effectiveness. A total of four levels can be distinguished:

1. The task: information about how well the task has been carried out
2. The process: process-oriented feedback that is necessary to be able to perform the task properly
3. Self-regulation: information about how a student monitors the own learning process, such as the student's reflection, motivation, control, and self-confidence
4. The person: general compliments or personal disapproval and is the least effective

Reflection is needed to learn from experiences. This skill is indispensable in the development of balanced professional behavior and learning (Maudsley and Strivens 2000). Critical self-reflection enables academics to listen attentively to themselves, to recognize their own mistakes, to refine their (guidance) skills, to make fact-based decisions, and to clarify their values, so that they can act with compassion, attentive presence, and insight (Guest et al. 2001). For this reason, it is desirable that not only students, but also academics continue to examine themselves. Supervision is a good tool for this. Supervision is not about a current work problem on the part of the person being supervised, but about the current meaningful experience in professional action. This will permit the individuals to gain insight into the actual and desired meanings of one's actions. Supervision aims to achieve the development of independent functioning as an academic on the basis of the integration of feeling, thinking, acting, and wanting.

A handy model that can be used for developing reflection is that of Argyris and Schon (1974). According to this model, learning takes place at three levels, ranging from evaluative to reflective learning, which are interconnected. The goal is to achieve the third level, reflective learning:

1. Single-loop learning (evaluative learning) is about "what do I do?" and "how can I do better?" Learning is aimed at improving one's actions and improving the existing situation through new rules. The question is: "am I doing it right?"
2. "Double-loop" learning is not only aimed at improving behavior, but also at the underlying motives and beliefs (thinking and feeling). The discovery of these underlying patterns and the reframing of these patterns into new knowledge are central. The question then is: "am I doing the right thing?"
3. "Triple-loop" learning (reflective learning) focuses on exploring the personal motives/deeper values and becoming aware of them. It is all about what one wants to do at the deepest level and whether it is ethically responsible. The question here is: "Do I do it for good reasons?"

Reflection should not get stuck in the reflecting, but should be converted into action. The process of experience becomes an intentional learning process in which the experiences are processed in a reflective way and these lead to new insights.

Conclusions can be drawn from these insights as to how to deal with them in the future. In fact, the same steps are applied as for the feedback questions. The more an academic is able to reflect on the basis of triple-loop learning, the more stability will be achieved and as a result one will be better able to contain one's own emotions and those of others.

14.3.4 Cornerstone: Servant Leadership

Managing autonomous and continuously developing academics on the basis of hierarchy and planning and control is not possible. As indicated in Sect. 14.3.1, academics are not very sensitive to power from the hierarchy; however, they are sensitive to authority. The difference between the two is that authority is granted by the academics. To be granted as authority, the following elements are needed: (1) professional expertise; (2) empathy, involvement with the people in the organization, knowing what is going on and by feeling personally rather than formally responsible; and (3) serving instead of enforcing (Weggemans, 2014). To be effective as a servant leader, the softer emotional competencies must also be well developed.

Research by Müller and Turner (2010) shows that demanding and complex projects require attention to the academic; simple projects require particular attention to the processes. On this basis, they argue that in complex projects, transformational leadership is important because it improves team performance (Stewart, 2006); in simple projects, it is transactional leadership. Despite this finding, we deviate from this advice and opt for servant leadership; servant leadership has many similarities with transformational leadership, but also clear differences.

Similarities are: transformational leaders and servant leaders are visionaries, they generate high levels of trust, serve as role models, show consideration for others, delegate responsibilities, empower followers, teach, communicate, listen, and influence followers.

The main difference is the focus of transformational and servant leaders. Transformational leaders have a greater concern for getting followers to engage in and support organizational objectives (Stone et al. 2003: 25). The servant leader believes that organizational goals will be achieved on a long-term basis only by first facilitating the growth, development, and general well-being of the individuals who comprise the organization. For this reason, servant leaders do not serve primarily on results; but rather focus on service itself. The servant leader believes in the intrinsic value of each individual; it is all about recognition, acknowledgement, and the realization of each person's abilities and that the persons can still learn (Dierendonck, 2011). This belief is in line with Henderson's vision on nursing and the ICF's on human functioning. For APNs, servant-leader beliefs are easily recognizable as they match with how they act with their patients.

> Servant leadership is defined as: *an other-oriented approach to leadership manifested through one-on-one prioritizing of follower individual needs and interests, and outward reorienting of their concern for self towards concern for others within the organization and the larger community* (Nathan et al. 2019).

Six characteristics can be distinguished for this type of leader (Dierendonck, 2011):

1. *Humility,* this competency is related with daring to admit that they can benefit from the expertise of others. They actively seek the contributions of others. Humility shows in the extent to which a leader puts the interest of others first, facilitates their performance, and provides them with essential support.
2. *Authenticity,* this competency is closely related to expressing the "true self," expressing oneself in ways that are consistent with inner thoughts and feelings. Authenticity is related to integrity, the adherence to a generally perceived moral code. Authenticity is about being true to oneself, accurately representing—privately and publicly—internal states, intentions, and commitments. A servant leader's authenticity manifests itself in various aspects: doing what is promised, visibility within the organization, honesty, and vulnerability.
3. *Interpersonal acceptance,* this competency is the ability to understand and experience the feelings of others and where people are coming from and the ability to let go of perceived wrongdoings and not carry a grudge into other situations. Interpersonal acceptance includes the perspective-taking element of empathy that focuses on being able to cognitively adopt the psychological perspectives of other people and experience feelings of warmth, compassion, and forgiveness in terms of concern for others even when confronted with offences, arguments, and mistakes. For servant leaders, it is important to create an atmosphere of trust where people feel accepted, are free to make mistakes, and know that they will not be rejected.
4. *Empowering and developing people,* this competency is related to a motivational concept focused on enabling people; empowerment aims at fostering a proactive, self-confident attitude among followers and gives them a sense of personal power.
5. *Providing direction*, as also mentioned by Weggemans (2014) this competency ensures that people know what is expected of them, which is beneficial for both employees and the organization. A servant leader's take on providing direction is to make work dynamic and "tailor made."
6. *Stewardship,* this competency is related to the willingness to take responsibility for the larger institution and to go for service instead of control and self-interest. Leaders should act not only as caretakers but also as role models for others. By setting the right example, leaders can stimulate others to act in the common interest.

The first three attributes are about the leader as a person; the last three about what he or she does. These characteristics show that servant leadership is not a leadership style, but a vision. Essential to this vision is the belief that leadership should contribute to the development of people and that they become healthier, wiser, freer, and more autonomous and in turn serve others. All this requires a culture in which learning is allowed and in which safety, making mistakes, and honesty are central concepts (Dierendonck, 2011). Honesty is necessary to understand the needs of

colleagues and to guide and coach them individually and as a team. It requires that managers not only coach and supervise colleagues from a rational perspective, but also that they know how to make use of their intuition and discover the individual values and motives of each colleague.

Servant leadership, unlike many other leadership models, places less emphasis on rational thought, but more on intuition. Intuition characterizes a more holistic approach in which the academic as a whole is looked at in the context of the work and the team and demands made on the academic from a social perspective. This is also in line with (neuro)psychological research that shows that our decisions are actually made by our intuition. If you think you have made a decision on the basis of reasoning, you may feel that the reasoning was made on the basis of reasoning, but in fact the reasoning follows the intuitive assumption of what the decision would be (Kahneman, 2012; Mlodinow, 2012).

Research (Müller and Turner 2010; Nathan et al. 2019) shows that servant leadership has positive effects on: (1) behavioral outcomes, e.g., collaboration among employees, helping behaviors, and team effectiveness; (2) additional outcomes, e.g., engagement, job-satisfaction outcomes, work–life balance, commitment, psychological well-being, and empathy; (3) trust in the leader, e.g., perceived leader effectiveness and perceived leader integrity; and (4) performance outcomes, e.g., employee and team performance, innovation-related performance outcomes, customer-oriented performance, knowledge sharing, service quality, and team efficacy.

Working on the basis of servant leadership within a team of academics should not only be reserved for the academic coordinator. For good teamwork, but also because of their role as teachers, faculty can be expected to recognize and acknowledge the capacities of each student and to realize that each student can learn in his or her own way. In fact, these are also qualities that you need as a teacher in the role of coach and supervisor (Azer et al. 2013). The supervisor can therefore be expected to stimulate colleagues in this role and that these academics will mobilize servant leadership techniques again in the guidance and coaching of students and stimulate the team's functioning.

14.3.5 Cornerstone: Personality Traits and Leadership

Weggemans (see Sect. 14.3.1) has formulated nine competencies for leaders. These largely correspond to those of servant leadership. But are there any personal characteristics that further determine the effectiveness? To determine whether personal characteristics determine the (in)effectiveness of leadership, Judge et al. (2002) carried out a systematic literature review; the personality characteristics were examined. This shows that leaders score higher on the qualities of openness, extraversion, and conscientiousness, and lower on neuroticism. However, additional research shows that effective leadership is only connected with a higher score for conscientiousness and a lower score for neuroticism; extroversion, openness, and altruism were in no way connected with effective leadership (Yeh et al. 2016). The BIG-5

personality theory refers to conscientiousness as: the degree to which a person works in an organized and purposeful manner. A conscientious individual is ambitious and reliable. Someone who scores low on this dimension is better able to deal with chaos and therefore works in a less structured way. Neuroticism is defined as: the extent to which someone is concerned. Neurotic people are insecure and nervous. People with a low score on this dimension are emotionally stable. They are satisfied with themselves and are less likely to worry.

14.4 Conclusion

In order to graduate highly competent APN clinicians and leaders, strong academic standards for APN education are essential. When developing these standards, the first step is developing a vision, the why of the program. This not only provides the overall aim of the program, it will attract peoples' attention and provide direction for the choices to be made to obtain this aim, the how of the program. The how should not be restricted to vision on the role of APN, education, assessment, and quality assurance, but also to the culture academics should work in. After all, academics constitute the most important capital of academia. They are highly intrinsically motivated with a high self-management capacity, but they do not want to be told what to do. Academics want to be inspired where to go to, and if they do not get their professional freedom, they struggle along. But if you create a collective ambition in academics, give them freedom by means of professional governance, let them work and learn within a community of practice, and maximize their affective bonding with the academic goals and the congruence between their personal goals and those of the organization, then their energy level will increase. Finally, this will process will stimulate their inclination towards internal entrepreneurship and propagation of the vision of the role of the APNs in clinical practice, on the educational program, and on assessment. The role of the academic coordinator is to coach their academic colleagues by means of servant leadership. These concepts of servant leadership are in line with Henderson's vision on nursing and the ICF's classification on human functioning. These concepts are easily recognizable as they match with how APNs act with their patients, and thus this form of leadership is easy to accept and understand for APNs. And within this culture, no one thinks about "what they do," as it is obvious that they train students to become highly competent professionals.

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A Quality and Policy Focus to Academic Leadership

15

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Academic institutions and APN faculty must prepare the next generation of advanced practice nurse (APN) leaders to be equipped with the necessary capacity to improve patient care and organizational effectiveness and efficiency (Lamb et al. 2018). The vision for APNs worldwide is to provide access to high-quality, cost-effective health care locally and globally. This chapter provides a roadmap for areas of expertise that APN educators must integrate into educational programs to prepare leaders for the future including establishing leadership content, developing interprofessional educational experiences (IPE), integration of healthcare quality, policy and scholarly activity into practice, and building alliances for educational excellence.

The foundation of leadership requires innovative thinking. According to Drucker (1985), innovation is purposeful, methodical approach to change. Recently, in the United States, the Affordable Care Act forced innovative thinking for improved patient care delivery (Pillay and Morris 2016). Changes in care delivery in other countries such as implementation of private insurance changes in South Africa required innovative approaches to address the changes. A study conducted by O'Brien et al. (2011) found that chief nursing officers who completed more leadership courses tended to be more innovative and scored higher on innovation scales

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than those who had completed fewer courses, hence supporting the notion that leadership can be taught. Change requiring innovation is occurring worldwide.

In order to effectively prepare APN leaders of the future, curriculum in APN programs should include competencies in communication, relationship building, visionary thinking, resilience, and technological management. While many competencies can be identified that are useful for leadership development, the focus of this section is on the noted competencies because of the foundational nature of each.

Using a stepwise approach of teaching of skills, APN students can first be introduced to specific concepts of leadership skills (didactic course content) and then practice the learned skills (simulation lab and clinical practicum courses). For programs that do not have simulation labs, skills can be practiced in the classroom and then in the clinical setting. A variety of methods can be used to teach leadership including team-based assignments, simulations, and self-reflection exercises. In addition, leadership learning experiences can be developed within different clinical contexts including outpatient, acute care, and long-term care. As with any other skill, after graduation, the APN in practice is a novice leader. With structured coaching, mentorship, and development, the novice APN leader can develop into a mature and innovative leader.

15.1 Leadership Education

Teaching leadership skills is essential in the education of all APNs in order to empower APNs to lead change in health care that will improve our patients' lives. The beginner level of leadership knowledge serves as a foundation for advanced learning. Therefore, nurse educators can focus on the leadership knowledge, skills, and abilities of the APN throughout the curriculum leveling the learning experiences to beginning, intermediate, and advanced timelines. The specific content for leadership development of *communication, relationship building, establishing a vision, resilience development (adaptive decision-making)*, and *technological management* are essential to leadership development.

Communication. Communication is the cornerstone of leadership. Effective communication skills are essential to achieve outcomes whether they are patient or organizational/systems focused. It is essential that APNs be able to communicate a vision of care, motivate teams to do better, provide information that is meaningful and timely, and be able to integrate all of this into practice. Effective communication requires being present and often to be silent and hear what others have to say.

Communication at the beginning level includes having students understand the elements of effective communication and analyze case studies of effective and ineffective communication. At the intermediate level, students can practice communication skills with feedback in the simulation lab communicating with patients, working with team members in the care of a complex patients and/or doing handoffs of patients to team members or during transitions in care. In addition, team assignments can be integrated into coursework that requires 4–5 students to work together on a project with part of the experience to assess the effectiveness of

communication among team member and development of a plan to improve team communication. At the advanced level, students can practice leadership skills within the clinical setting—depending on the constraint of the setting. They can be assigned to lead a clinical care team or a quality improvement team and practice conducting meetings.

Relationship building. Leadership depends on building relationships. The ability to relate to people is complicated and depends on many factors. One important factor in the ability to build and maintain relationships is emotional intelligence (Akerjordet and Severinsson 2008; Bar-On 2002, 2006; Carragher and Gormley 2017). Emotional intelligence is generally thought of as a trait, ability, or a combination of both in assessing interpersonal skills and is useful in understanding the emotional level of working and interacting with others (Austin et al. 2004; Snowden et al. 2015). According to Goleman (1995) who provided one of the first frameworks, emotional intelligence involves awareness of self and others and the ability to regulate one's emotional response. Emotional intelligence is important for APNs to build relationships with patients and within the organization and can be improved and enhanced with practice (Dutoglu and Tuncel 2008).

In addition to the importance of emotional intelligence in building relationships, understanding the importance of trust and caring is crucial. Mutual goal setting and follow through yields trust. Trust aids in communication efforts. Trust breeds a sense of safety; physical and emotional safety support effective relationship building. Working within and leading teams requires emotional intelligence, trust and caring on the part of the leader as well as understanding the capabilities of each member of the team.

At the beginning level of learning, APN students can evaluate relationships that they have had that worked well and those that did not and analyze the elements of the relationship and how they managed their emotional responses in each circumstance. At the intermediate level, students can take an emotional intelligence self-assessment—many of the self-assessments are free and some are commercial products that charge a fee. In doing the self-assessment, faculty can provide support to the student to interpret and reflect on results. At the advanced level, students can be challenged to assess their emotional responses to patients and to team members when something went well and when it did not go well. Faculty need to debrief with students about this assignment.

Vision. Establishing a vision is a leadership skill necessary for creating and managing change. Visionary leaders tend to be more successful and use communication and relationships as facilitators for change (Cinar and Kaban 2012). Creating a future vision that can be clearly understood in terms of the "why" as well as the what, how, and who of the vision is important and helps followers buy into the vision (Cinar and Kaban 2012). The visionary leader relies on the engagement of his/her team to obtain the goal and does so by encouraging its members (Cheema et al. 2015).

Beginning students can be challenged by learning about notable leaders' vision within and outside of health care that is in a country-specific context. The intermediate level of learning can challenge students to think about what the vision for

themselves is in 5 years—what do they want to be doing and how are they going to do it. Creating a vision will help leaders to understand the challenges of creating a vision and the importance and relevance of doing this. Advanced students can be asked to create a vision for one of the clinical sites in which they imagine themselves the leader. This will require students to assess the current vision and the changes needed to provide high-quality care in the future.

Resilience. Resilience has been defined as a dynamic process in which a person possesses the ability to manage personal challenges or difficulties throughout life and adapt to them to grow stronger (Di Fabio and Sakloske 2018). Other terms used to describe this phenomenon are hardiness and grit. Resilience is related to the ability for adaptive decision-making, enabling leaders to lead or promote a vision or plan when constant challenges or difficulties arise. The leader's ability to engage his/her team in communication and relationship building become the basic building blocks to establishing a plan and then adapting to the challenges.

Resilience is developed throughout one's life, and the experience of being a student contributes to resilience. A beginning student can do a self-assessment using Angela Duckworth's grit scale that provides information about individual perseverance (Duckworth n.d.). The assessment is free and online with the score and interpretation provided at the completion of the short questionnaire. The student will need to debrief with a faculty member about what this means to the student and how resilience can be enhanced. An intermediate/advanced learning experience is having a student analyze a very difficult clinical situation and consider how they managed the challenge and how resilience or adaptive decision-making played out. Have them consider how effectively they managed the situation, how the situation contributes to their resilience, and how the situation has affected their continued passion and perseverance for pursing an APN role.

15.1.1 Technology Management

Technology use is a way of life in health care in many countries from the use of electronic health records (EHR) to patient monitoring systems to emerging use of artificial intelligence for diagnostic decision-making and patient treatment plans. Leaders in today's healthcare world likely do not know the programing and engineering details of technology development and maintenance, but they do need to know the use and application of technology to patient care and organizational effectiveness. Successful leaders involve technology innovators on their team to keep current in a very rapidly changing area. In resource-constrained countries, the use of technology may be limited and slowly emerging. In these situations, it is still essential for APN educators to be aware of advances to help assess what technologies may be the most cost-effective in their systems for the future.

In countries with EHRs, the beginning APN student will need to know how to enter data into an EHR as well as understand the usefulness of the data to improve care and effectiveness of systems. Having access to an EHR in a simulation setting to understand the organization and functional aspects of the EHR as well as practice

inputting patient care data is important. In addition, the beginning student will need to understand the availability and application of technology-based monitoring systems in patient care. An intermediate learning experience is determining how to use EHR-obtained data to improve patient care. Advanced learning experiences include extracting EHR data to lead a quality improvement process and documenting the process and outcome and also evaluating the use of a technology monitoring process.

15.1.2 Learning Environments in APN Leadership Education

Three learning environments are present for APN leadership skill development: classroom, simulation lab, and clinical setting. The academic setting including the classroom and simulation lab (as available) is used largely for the beginning and intermediate leadership education. The clinical setting is best used for advanced leadership practice. An APN preceptor can augment the education in leadership skills. Within the academic setting, the use of simulation allows a non-threatening environment for guidance and mentoring, and hence, learning. The clinical practicum experiences can be geared toward growing the APN leadership in real-life situations.

A variety of team-based activities incorporated into simulation and clinical practicum courses allow APNs to apply content learned in the classroom. It is often useful for APN students to journal throughout their education to recognize the progress they have made in building their leadership capacity (O'Flaherty et al. 2018). When journaling is used, feedback from their faculty and/or preceptor helps the student to process what they have written. Pillay and Morris (2016) encouraged the use of case studies of leadership successes as well as failures to aid in the development of leadership skills.

Teaching leadership is as important as teaching clinical skills. Just as in direct care, lives depend on the quality of care provided and the effectiveness of organizations in supporting care. APNs worldwide are well situated to be leaders of the change necessary to provide better healthcare access and quality.

15.2 Advocacy for Interprofessional Education

Another important aspect of APN leadership development is interprofessional teamwork. Current trends in health care include the care of complex individual patients and populations by advanced practice nurses. However, a single profession does not manage these patients alone. No single profession alone can respond effectively to the array of patient and population problems. Working in interprofessional teams to provide high-quality care is the goal of all health providers. According to the World Health Organization (WHO), along with the "Future of Nursing Report," educational institutions must develop a "collaborative-practice ready" workforce. To accomplish this, interprofessional education (IPE) must be integrated into

healthcare profession programs. IPE is defined by the WHO (2010) as "when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes." While the concept seems simple, it can be difficult to operationalize. As a vital component of nursing education, IPE leads to improved communication, ultimately increasing the quality of patient care, and is a real-world framework for education and clinical practice.

15.2.1 Leadership and IPE

Leadership is critical to the implementation of IPE in healthcare education. Historically there have been lackluster efforts to truly develop and integrate interprofessional education among the health professions. We have discussed this for 40 years and are still talking about doing it. Clear commitment from leadership is necessary and must not just be on paper. IPE should be evident through the actions of leaders and the investment of resources. Any efforts in IPE should be recognized, making it visible and rewarded to those within the healthcare programs and across the institution or institutions. As expected, resistance to change may be seen as implementing IPE can be very challenging and will involve a willingness to change by all health profession programs. While IPE is essentially the same around the world, team dynamics within various cultures should be addressed. This understanding will give a leader an advantage in how best to navigate IPE in their country.

Leading an IPE initiative entails understanding that resistance is inevitable, and an adaptation and culture change must occur. For instance, resistance toward an initial IPE effort at a major academic health center included using differing class times among the professions, stating that faculty were fully engaged and could not take on additional teaching responsibilities, and adequate space to accommodate IPE was not available. After further exploration, the resistance was based on failure of decision-makers to believe in the importance of IPE.

Embracing IPE requires engagement and dedication rather than a technical solution. Leaders must have the ability to address this resistance to change and employ strategies to effect this change. Valuing partnerships and interactions with other professions is essential to building relationships for a successful IPE program and improved health outcomes. Knowing that learning from or interacting with students in other professions can improve communication gaps, collaboration is key to pushing the mission of IPE.

15.2.2 Build Meaningful Learning Experiences

Foundations of IPE. While many believe that working together in a team for patient care is an innate skill requiring no fundamental education, often the opposite is true. Basic education on team skills, foundations of collaborative practice, and effective communication should be at the core of healthcare programs. Working in groups

and truly being a functional IP team requires dedication and an understanding of each profession. It is important to note that healthcare teams look different around the world. These teams often function differently in various countries and settings. By understanding this viewpoint, the APN leader can formulate strategies to navigate the notion of IP teams in education and practice. Integration of the four domains of the IPEC competencies is the foundation of IP education and can be considered a global perspective: (1) values and ethics for interprofessional practice, (2) roles and responsibilities, (3) interprofessional communication, and (4) teams and teamwork (IPEC 2016).

To be effective, the IP team establishes ground rules of mutual respect and trust, a circle of safety between members, along with open and genuine communication. A fundamental principle of interprofessional education and practice is that the team be committed to training together. IPE helps advanced practice nurses and other healthcare students understand the roles of each profession by sharing experiences. By eliminating the silos of care, healthcare will be delivered in a way that achieves better health outcomes more economically.

Seeking alternative IPE activities within the clinical setting can be valuable and inexpensive. For example, participating in interprofessional hospital patient rounds by the healthcare team or working with healthcare team members in a clinic setting will provide real-time practice in navigating IP communication and collaboration challenges.

Case Discussions. Healthcare programs must build learning experiences that are meaningful. Integrating case discussions into the curricula develops skills where healthcare teams are working together to create a plan of care for a specific population. Built into these discussions should be an analysis of how varied needs are going to be assessed and met by an interprofessional team as well as how the process of care will be provided. Students begin developing the skills to work together, share knowledge, and navigate a collaborative practice. For example, students from various professions could collaborate in small groups during class time or even within a virtual environment to work through a case study related to a certain patient situation. Each profession would work through the case with other team members to formulate a diagnosis and treatment plan. This could be scaled for different size groups, professions, and patient situations.

Simulation Experiences. While clinical experiences may vary and practically have limited IP focus, simulation experiences can provide consistent and standardized realistic interactions for health professionals collaborating as a team. Simulation allows learners to practice IPE concepts without fear of patient harm and can support a nurturing and interactive environment to promote inter-professionalism. Bringing different professions together early on in the educational process helps dispel negative stereotypes that may impede partnering in clinical practice. Simulation experiences can provide a safe environment for healthcare teams to practice team concepts allowing them to receive feedback on strategies to improve their care.

One example of a low-cost simulation experience would be using a colleague to portray a patient who presents to the "simulated ER" needing to see a healthcare

provider for specific symptoms. The advanced practice nursing student would care for that patient by performing a physical assessment and taking a history and then applying diagnostic reasoning skills develop an appropriate course of treatment. They would then collaborate with the healthcare team, which could consist of various team members, to develop an appropriate plan of care. This could also be done virtually or perhaps by a phone call to another provider such as the dietician or a specialist to collaborate on an appropriate plan for that patient.

For a higher acuity setting, a higher fidelity simulation experience could be developed whereby the healthcare team is called to care for a deteriorating patient. Healthcare team members such as respiratory therapists, physicians, and pharmacists could collaborate together to help support that patient and provide appropriate care. By working in a team within a crisis situation, team members quickly learn roles and how to work within a team. This simulation could be adapted for many interprofessional clinical events.

15.2.3 Organizational Leadership Support

Resources. While IPE may be incorporated into courses or programs, IPE must be established at a higher level across the institution. Leadership and administrative engagement and backing are crucial in order to develop and maintain an IPE program. Financial support through creating budget lines specific to interprofessional education should be implemented with a plan for ongoing sustainability of these programs. Funding and prioritization of the IPE initiative are essential to its enduring success. While financial support is important, often when initiating an IPE program, funds may not be available. This should not become a hindrance to moving the IPE initiative forward. Being creative and starting simply to gain excitement and energy for IPE can plant the seed for growing and developing an IPE program.

When considering an IPE program, one must consider human resources in getting IP activities started. It is essential to identify champions of IPE and identifying a variety of professions that would want to participate and give their time to the mission of IPE. While having a budget and earmarked monies for developing and supporting IPE is ideal, having the excitement and engagement of an identified IPE "team" may be even more valuable at the foundational beginnings of an IPE program.

Organizational Structure. Creation of an organizational structure that includes all professions working toward the same goal is essential to IPE. Advanced practice nurses play an important role in IPE. By leading IPE in healthcare education and translating IPE into clinical practice and the day-to-day patient care is important. Teaching and leading advanced practice nurses how to lead the initiatives to grow and sustain IPE in healthcare education but more importantly in real life. Collaboration should be the norm and not the exception. Dedicated clinical/academic positions can be the driving force to the promotion and development of interprofessional education in the institution and translating over into clinical practice.

15.2.4 Future

Advanced practice nurses are at the forefront worldwide in developing creative and innovative ways in the preparation of health profession students working in collaboration. In order to change clinical practice from healthcare professionals working in silos to collaborative-ready teams, it is essential for interprofessional education to be at the root of education for our future providers.

15.3 New Knowledge to Improve Quality Care and Inform Policy

APN practice needs to continually be informed by scholarly activity—generating knowledge and integrating new knowledge into practice. It is critical to the future of APNs worldwide to engage in robust quality improvement to keep moving toward the highest quality of care and also to engage in evidence-based policy generation.

Quality improvement and policy generation are tightly related for APN practice to evolve. For the countries beginning the APN role, policy-makers at the regulatory and lawmaking levels need to understand the benefits to patients, populations, and the country of supporting APN practice. In the United States where the NP role first began, a number of studies demonstrated that NP care was equal to or better in some cases than MD care (Office of Technology Assessment 1986; Congressional Budget Office 1979; Mundinger et al. 2000). It is important for APNs establishing the APN role to convince policy-makers, health systems, and patients that APNs are critical providers in the healthcare workforce.

Countries in which the APN role has been firmly embedded in the healthcare structure should focus on quality improvement work that will improve care rather than continuing to justify the existence of the role.

APN programs have a responsibility to prepare graduates to engage and lead quality improvement efforts. APN education takes place within institutions of higher learning with the expectation that faculty and graduate-level students will understand, generate, and apply new knowledge. The mission statement of most universities and colleges incorporates the ideas of creating and disseminating new knowledge. Accreditation standards for educational programs include expectations of scholarly activity. The American Association of Colleges of Nursing (AACN) defines nursing research as, “those activities that systematically advance the teaching, research, and practice of nursing through rigorous inquiry that (1) is significant to the profession, (2) is creative, (3) can be documented, (4) can be replicated or elaborated, and (5) can be peer-reviewed through various methods” (AACN 1999: para 7). AACN also supports Boyer’s framework for scholarly activity which expands the framework for research. Using the Boyer framework, AACN has established that DNP project requirements should be related to improving patient care.

The Boyer model was intended to better integrate the multiple roles that faculty have in academic settings. He proposed a model of scholarship that included four areas:

- The scholarship of discovery including original research.
- The scholarship of integration involving the synthesis of information across disciplines, across topics within a discipline, or across time.
- The scholarship of application (engagement) which applies to the using of results for specific purposes.
- The scholarship of teaching and learning focusing on the systematic study of the teaching and learning process (Boyer 1990).

The Boyer framework provides a practical way for APNs to define their scholarly work. For example, applied scholarship could be taking an idea and applying it to a particular situation. For instance, a specific training program to teach administrative staff constructive and sensitive patient interactions has been rigorously tested and is valid and reliable for hospital staff. The scholarly application may be the implementation and testing of the training program in outpatient care. Integrative scholarship could involve integrating findings from social work, medicine, and other disciplines to develop and test a model of care in managing the health of a population.

In addition to the educational standards noted above, standards of practice for APNs include statements related to APNs generating and integrating new knowledge into practice. For instance, the International Council of Nursing describes one characteristic in APN practice as, "Integrates research, education, practice and management" indicating that research is an integral part of APN practice (ICN 2019). Parker and Hill (2017) reviewed several countries' positions on APN practice. The Canadian Nursing Association in their framework for APNs states, "Advanced practice nurses are committed to generating, synthesizing, critiquing and applying research evidence" (Canadian Nurses Association 2019: 32). In addition, Hong Kong SAR incorporates the statement, "Advanced nursing practice is built on advancement of nursing knowledge and expertise with reflection on practice and research" (Nursing Council of Hong Kong 2015: 4). Australian Nursing and Midwifery Accreditation Council (2015) recognizes that research and practice improvement methodologies are part of practice capabilities implying that these skills should be included in the education of APNs. These statements of professional standards reflect the importance of APNs worldwide to continually seek to engage in scholarly activity to improve care. APN educators and students are expected to participate in the creative and systematic process of creating and integrating new knowledge into practice.

15.3.1 Quality Improvement

Quality improvement and research have been differentiated by academic institutions and clinical care organizations. The major differentiator is the protection of human subjects. Quality improvement involves work to improve care that is specific within an organization, is not intended to be disseminated, is not generalizable, and does not require human subject approval. However, quality improvement processes are moving toward a more robust and systematic approach as improvement science

is emerging. The small tests of change that are part of the quality improvement process can be developed into more generalizable science, which would then be considered research. Research is the systematic process of asking a question, creating a hypothesis, and testing the hypothesis. The information obtained from research is intended to be disseminated and generalizable. Research clearly needs to be reviewed by a human subject committee to safeguard the rights of patients.

The challenge to APN educators worldwide is to integrate meaningful scholarly content and experiences within clinical roles. Students engaged in APN programs focus on developing their expertise in clinical care and decision-making. While students recognize the importance of new knowledge that will improve care, often their concerns center on making the right clinical decisions to manage patients effectively and safely at the moment.

The approach to preparing APNs to integrate quality improvement into their practice requires creating the mindset of consistently asking questions such as: Is this the best way to provide care? Are my patients getting the best care possible? How can our team improve the outcomes for our patients? Faculty need to create the thinking that quality improvement is integrated into practice, not as an add-on or occasional activity. Faculty need to believe this in order to communicate and be a role model to foster a new way of thinking. In addition, students need the knowledge and skills to act on quality improvement. This includes knowing the quality improvement process, implementing small tests of change—the plan, do, study, act (PDSA) process and continually monitoring the outcomes.

Quality Improvement Process. The quality improvement process includes identifying the problem, collecting data, conducting a root cause analysis, doing a PDSA, and then evaluating the outcome and continues to evaluate the problem. See the figure below that represents the generally accepted steps in quality improvement (Fig. 15.1).

Identifying the problem. Identifying the problem is based on data or observations. While economically advanced countries are more likely to have electronic health records (EHR) that can provide quality improvement information, countries

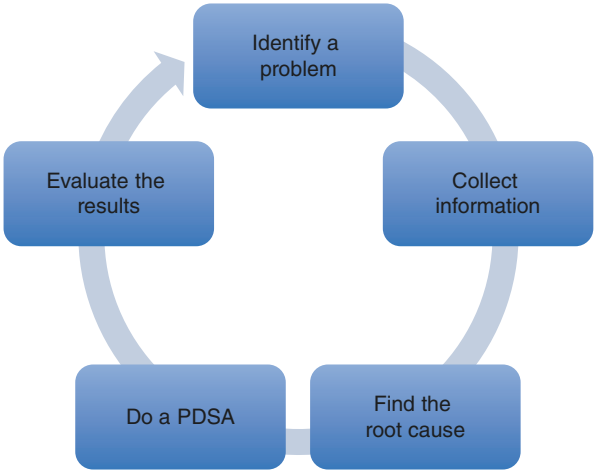

Fig. 15.1 Steps in quality improvement process

without EHRs can also track data. An example is a clinic in rural Eritrea where nursing staff kept track of immunizations, prenatal care, and other health issues by simply writing on the wall of the clinic. They knew all of the children in the village and kept track of the number immunized.

As long as a source of information is available to identify a problem, the problem should be stated in a way that is specific and clear. Specificity is important because the broader the problem statement, the more difficult it is to create an effective intervention. Instead of creating a broad problem statement such as "patients are dissatisfied with coming to the clinic," being more descriptive such as "patients feel that they are not received well by the receptionist when they enter the clinic".

Collecting information. Collecting information about the problem is the next step. Finding out what patients mean by "not being received well" would be important. Who is/are the receptionist(s) and what is the training about how to greet patients? What does being received well look like? Establishing the context of the problem provides important information to go to the next step that is to determine the root cause for the problem.

Root cause analysis. Several tools are useful in figuring out the root cause. The five whys help to drill down to the root cause with each "why." The Fishbone diagram helps a team organize information into categories such as processes, people, procedures, and others and then identify the possible causes of the problem related to each category. Also a variety of charts such as control charts, histograms, and Pareto charts can help determine the root cause of a problem.

PDSA. The problem statement, additional information about the problem, and root cause all contribute to doing the PDSA. The PDSA process is an iterative cycle. The plan includes what are the objectives, predictions, and plan (who, what, where, when, and how). The do is to carry out the plan and keep records of the process and outcome. Study is comparing the results to the predictions based on data analysis and figure out what was learned. Finally, the Act is to identify changes needed and start the next cycle (Fig. 15.2).

Continue monitoring. The study and do parts of the PDSA set up the next iteration. The problem identified may need to be restated and/or the plan revised. Ongoing evaluation of the problem is the key to actually fixing the problem and sustaining the improvement.

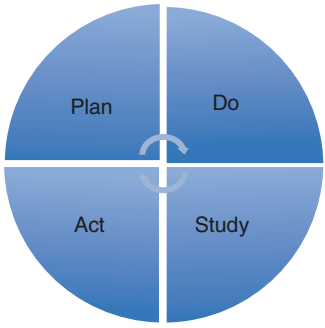

Fig. 15.2 Plan, do, study, act process. (Figure adopted from IHI and developed by Associates in Process Improvement 2019)

Knowledge of measurement and frameworks. In addition to the problem-solving process, students are going to need to understand quality measurement. They will need to know what constitutes a good measure, what is variation, and why it is important. They will also need to know the frameworks for quality improvement including structure, process, outcome; STEEEP (safe, timely efficient, equitable, effective, and patient-centered), and overuse, underuse, and misuse. The frameworks provide the guide to the type of measures that are relevant in assessing care.

Students need to build on the knowledge base of quality improvement through experiential learning. This learning can be in the form of leading or participating in a quality improvement project in their clinical learning setting and could be incorporated into their scholarly project. APN students will need to have the experience of doing quality improvement in order to integrate it into practice as graduates.

15.3.2 Policy

The role of the APN in policy ideally furthers the knowledge about how to help the populations in every country be healthier. The major legs of the policy stool are cost, quality, and access. APNs need to approach policy from an evidence-based perspective. It is not enough to tell policy-makers that APNs make a difference in providing access and reducing cost while providing high-quality care. Policy-makers need accurate data to support APN practice.

Whether the policy-maker is at the institutional level determining policies that influence care providers, or at the national level creating policies for the country's healthcare system, all levels of policy-makers need evidence to make good policy decisions. APNs need to know the major concerns or interests of policy-makers and leverage those concerns in defining scholarly projects. Students can begin this process in their educational programs with faculty who are engaged in policy-related scholarly activity. In order to initiate, ensure APNs can practice to the extent of their license and make sure that the licensing or certification of an APN matches their educational program competencies, faculty, students, and practicing APNs need to continually work together to monitor and inform policy.

Students need to understand the laws and regulations of their country regarding health care. Nurses frequently shy away from understanding the finances of their system, but understanding where funds come from to pay for care and how they are allocated is critical to understanding priorities and programs and knowing how to leverage funding. Students need to know who the major players are in health decision-making including the stakeholders and their level of influence on decision-making. Usually legislative and regulatory bodies have special committees that govern health as well as special staff who have health as a focus.

APNs should consider the types of questions that need to be addressed to advance their roles and improve care through policy. Early in the development of the APN role, the following questions will be useful: Do APNs have the same, better, or worse patient outcomes than MDs in treating a specific population for a specific

health issue? Do APNs improve access to care for people living in specific geographic regions? Do APNs have more referrals, order more laboratory tests (depending on the availability of laboratory tests), prescribe more medications or alternative treatments than MDs? In countries that are establishing the role of APN, the policymakers to influence are likely boards or ministries that govern nursing practice as well as regional and national legislative bodies. Always remember that evidence-based policy is best focused on patient care impact.

15.3.3 Moving APN Research Forward in the Clinical Area

The clinical focus of the APN presents a challenge to the expectation of APNs engaging in scholarly work. APNs have the educational background to engage in scholarly activity, but they struggle with having time and support to do this. The clinical responsibilities of APNs are often barriers to conducting any type of scholarly activity. In a study of barriers to integrating evidence into practice for nursing, the two most powerful barriers were time and administrative support (Melnyk et al. 2012). In order to integrate scholarly activity into practice, the organization's leadership needs to value the contribution to quality care that scholarly activity can produce. One possible way to get past the barrier of time is for the APN to team up with a faculty researcher, either a nurse or researcher from another discipline, to generate clinically relevant knowledge. The win-win is that the PhD prepared nurse can have access to a clinical site, and the APN has helped to address the time constraints of practice because of having help.

15.3.4 The Future of APN Scholarly Activity

In order to continuously improve care, recognizing that the pursuit of new knowledge that will improve care is as important as developing clinical competencies. Both need to be melded into one—the APN sees the absolute link between safe and effective care and testing ideas and systematically pursuing answers to questions. While understanding and interpreting research findings is a critical piece of APN understanding of research, APNs may need help to integrate scholarly work fully into practice to improve care particularly in quality improvement and policy initiatives.

15.4 Strategic Alliances and Partnerships

Strategic alliances are critical to the success of high-quality APN education. Leaders are responsible for identifying and developing alliances that will benefit the educational program, school and university/college. Strategic alliances help to build educational programs and clinical experiences through leveraging the resources and expertise of partners. Strategic alliances exist when "two or more businesses work together to create a win-win situation" (Thompson 2019: para 2). Both parties in an alliance maintain their autonomy, whereas in a partnership, usually the blending of

resources and organizational structures occurs for mutual benefit. The key to the success of alliances and partnerships is mutual benefit. Each organization must feel that they gain something of value. The benefit of the alliance or partnership must be less costly than having to create that same resource within an organization. In education, strategic alliances and partnerships are needed in order to offer the best, most efficient, and most relevant education to APNs.

15.4.1 Academic Clinical Alliances and Partnerships

Several types of strategic alliances and partnerships are important to APN education regardless of where in the world the education takes place. One type of alliance is with practice partners. The move toward academic programs and clinical organizations to develop meaningful academic–practice partnerships is mutually beneficial in that educators are linked to practice and better understand the changing demands of clinical care and the clinical care organizations, and APNs are more prepared for the realities of practice. These partnerships help ensure that programs prepare a workforce that meets the real needs of employers. The partnership provides a continuous loop of updating education to the latest clinical practices to create relevant curricula and clinical organizations with more competent graduates.

In addition, the clinical partnerships provide preceptor experiences for APN students. Clinical placements are frequently difficult to establish and are required for APN students. Establishing agreements and close mutually beneficial relationships create stable placement opportunities. Depending on the country, clinical partnerships for APN education require formal agreements stipulating the expectations for both parties with academic institutions maintaining responsibility for evaluating the student and the clinical site providing clinical supervision.

Academic–clinical partnerships are also important for faculty practice. Many countries have requirements that APNs maintain clinical practice to keep knowledge and skills current. Faculty bring not only patient care expertise but also research and quality improvement expertise that could complement the goals of the clinical organization. Faculty are also often needed to provide adequate staff to care for patients. The educational organization has the opportunity for faculty to meet requirements of practice for continued licensing and/or certification and maintain and expand their clinical expertise to stay current in clinical practice to continually refresh the content for educational programs. For APNs the practice partnerships include not only hospitals for CRNAs and acute care NPs but also community-based providers such as Federally Qualified Community Health Centers or group practices.

15.4.2 APN Alliances and Partnerships with Other Academic Institutions

Strategic alliances and partnerships can also include other nursing programs in which courses are shared and joint degrees offered. This practice allows organizations to

be efficient and avoid programs that are not financially sustainable due to small numbers of students. Such partnerships also broaden availability of faculty expertise. Shared programs often need to be in the same geographic region for on-campus programs. However, for academic institutions that have developed web-based programs, the partnerships can be with any institution in the world.

The challenges of partnership programs may include language differences, recognition of courses/credits, and blending of faculty, so that faculty are knowledgeable about each institution's policies, and figuring out the tuition payment issues. The financial issues are often the biggest barrier but can be overcome with creativity. An example of academic partnerships is a public and private institution offering an APN Master's program with each institution taking responsibility for teaching specific courses. The private institution taught four of the 15 required courses. These four courses were offered in an academic health center and would have been very expensive for the public, community-based school to develop and teach. The remainder of the courses were taught at the public institution with a lower tuition rate, so the overall tuition was significantly lower for the joint program than the private institution could offer. The public institution granted the degree and collected the tuition dollars for both the public and private institutions and then paid the private institution the tuition for their courses. In order to have a mutually beneficial financial arrangement, the private school gave back to the public school 20% of their tuition that could go to hiring more faculty or administrative staff at the public school. Faculty teaching in the program had appointments at each institution. This partnership transcended the issues of a public and private institution, differing tuition rates, and joint faculty appointment and lasted for 30 years (Pawlson and Harper 1993).

Another example of a partnership model involving seven different nursing schools is a midwifery program in which one of the institutions offers courses online for the other institutions. The six institutions were interested in offering a midwife program to meet the interests of their students, but the number of interested students was limited, and therefore, the cost outweighed the benefit of offering the program. A creative solution was that students enrolled in one of the six institutions as their home, degree-offering institution, and completed the required core courses from their home institution and then completed the midwifery courses at the institution offering the mid-wife program. This partnership has provided a way to address the interests of students and uses existing resources efficiently by combining program content.

In addition, increasing numbers of partnerships among academic institutions are emerging internationally to provide APN students and faculty worldwide experience with health systems and cultures different from their own. The student and faculty exchanges benefit both participating institutions by the visiting students and faculty interacting with others at the hosting institution and the students and faculty going back to their home institution with expanded perspectives on the role of the APN. While many of the exchange programs are established between institutions, programs are available that support exchanges beyond the specific institutions. For example, The Fulbright Program run by the Council for International Exchange of Scholars (CIES) offers funding for a number of different types of opportunities for US students and students from other countries (CIES

2019). While awards are offered in many different disciplines, APN students and faculty worldwide are eligible to apply to these programs.

15.4.3 Research Alliances/Networks

Another opportunity for APNs is to create clinically based research that can inform improved patient care through quality improvement projects in partnership with a variety of clinical settings. The APNs can develop geographic research networks or networks based on areas of common interest. These groups can be established throughout the world to share data such as the International Nursing Network for Research in HIV/AIDs (Holzemer 2007). Professional organizations often provide the impetus for creating both practice and research networks. For instance, the International Council of Nursing (ICN) has APN practice networks and also facilitates research and learning networks. ICN has the Nurse Practitioner/Advanced Practice Nurse Network with a subgroup in research to:

- Support nurse practitioners and advanced practice nurses in practice and policy related research
- Facilitate the provision of resources, tools, and advice to NPs/APNs seeking to undertake research in their practice settings (ICN 2019: para 2).

Sigma Theta Tau also supports research partnerships internationally by providing information about research resources and the specific work of individuals. They provide grant funds to researchers to promote evidence-based practice. While not specific to nurse practitioners, APNs are clearly eligible to submit proposals.

15.4.4 Building Alliances and Partnerships

APN educational leaders need to continually scan the environment for opportunities to establish alliances and partnerships. The partnerships can enrich everyone involved. Going to professional meetings and networking with APNs who are doing research or presenting innovative practice models congruent with areas of interests provides the opportunity for developing partnerships. Being knowledgeable about changes in laws or regulations related to APN education and practice often provides the impetus to partner in order to meet new requirements. For instance, in the United States, the move from certificate to Master's programs in the early years of NP education required creative partnerships for certificate programs to move to the graduate level. Anticipating future demands and skills of APN will guide the decisions about types of partners.

A major challenge in developing alliances and partnerships is that each institution has its own culture that was derived from the philosophy of the founders, skills of current leaders, type of work done, country and geographic region, laws and regulations, comfort with risk taking, and professional expectations. There is a long

history of organizations that began a partnership and could not sustain it mainly because of significant cultural differences. Alliances with organizations with different cultures tend to be successful when there is:

- Agreement about the goals of the alliance
- Clearly defined mutual benefits
- Two-way communication incorporating the right information
- Ability to anticipate and recognize problems when they occur and have inclusive decision-making about the response
- Enjoyment of alliance leaders in working with each other
- Clarity about investments in the alliance

In creating strategic alliances and partnerships, it is most useful to look at the alliance as a long-term strategy rather than short term and temporary. Alliances and partnerships take time to build and nearly all run into unanticipated problems. These problems need time to work through and to reset the relationship. It is useful to establish a structure and timeline for evaluation on an ongoing basis, so that honest conversation can take place about any issues that are going well and not going well, misunderstandings related to expectations, as well as accomplishments of the relationships. Having timely meetings to evaluate the alliance will also provide information about whether to continue the alliance.

While working through issues can ensure a long-term successful alliance, there may be reasons to discontinue the joint work. The reasons may be that problems cannot be successfully resolved or that the mutual benefit that was expected is not possible. When feedback indicates that further financial or personal investment in an alliance or partnership does not add value, it is time to discontinue the alliance. The best outcome in discontinuing an alliance is for both parties to recognize that the alliance is not working and agree to dissolve the alliance amicably.

15.5 Conclusion

The world needs APN leaders who will move the dial on the quality of care provided to all patients and improve organizational efficiency regardless of the size of the organization. Academe can initiate the development of APN leadership capacity through thoughtful integration of specific leadership competencies. APN faculty need to be role models for future leaders and demonstrate engagement in leadership skills, interprofessional work, scholarly activity, and building of alliances and partnerships to better meet the challenges of education and clinical practice.

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Developing Advanced Practice Nursing Education, Practice and Policy in Eswatini

16

Julie Anathan, Colile P. Dlamini, and Louise Kaplan

In 2012, Seed Global Health (Seed) was established to support health system strengthening in Sub-Saharan Africa (SSA) in response to a growing burden of disease in the face of a critical shortage of health workers. Seed's unique focus is on developing meaningful, responsive and long-term partnerships with local training institutions, professional associations, and governments to enhance the learning environment to produce nurses, midwives, and physicians who are qualified to care for a range of healthcare needs of its population.

At center stage of today's global health discourse are the Sustainable Development Goals (SDGs) (United Nations 2019), Universal Health Coverage (UHC) (World Health Organization 2019a), and Primary Health Care (PHC) (World Health Organization 2019b). SDG 3.8 points to UHC to ensure everyone receives essential health services without financial hardship. PHC supports UHC by ensuring the healthcare workforce is enabled to provide quality access, availability, accessibility, and acceptability of services with respect to patient rights, needs, dignity, and autonomy. PHC, UHC, and SDGs cannot be achieved without a strong healthcare workforce, particularly nurses and midwives, who make up more than 50% of the healthcare workforce worldwide.

The core of a strong healthcare workforce is an education system with the quality and quantity of faculty prepared and enabled to effectively teach the next generation

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of nurses and midwives. Faculty provide the academic backbone, leadership, and vision that prepares graduates for success as clinicians, future educators, policy makers, and advocates. However, a severe shortage of nurses and midwives in Sub-Sahara Africa (SSA) negatively impacts the clinical environment and patient outcomes, as well as the learning environment for students in the classroom and clinical settings. Shortages limit faculty's capacity for professional development and innovation, and impair a country's ability to effectively respond to its health challenges.

Seed Global Health aims to address this challenge. Our strategy places US nurse, midwife, and physician educators at partner institutions for a minimum of one academic year to work side-by-side with faculty to strengthen the learning environment for students, offer professional development for faculty, and provide educational and clinical expertise in the development of new programs. Our guiding principles include: (1) establishing goals and priorities identified by our partner countries, institutions and communities, (2) our belief in the power of people to effect and sustain change, and (3) a commitment to long-term sustainable partnerships to deliver more lasting and meaningful improvements.

From 2013 to 2018, Seed established the Global Health Service Partnership (GHSP), a 5-year joint initiative with the Peace Corps and President's Plan for Emergency AIDS Relief (PEPFAR). Seed helped mobilize 191 physicians, nurses, and midwives to serve as year-long educators at 27 academic institutions across 5 African countries: Eswatini, Liberia, Malawi, Tanzania, and Uganda.

Seed's partnership with Eswatini, under GHSP, ran from 2016 to 2018. The Eswatini Ministry of Health invited GHSP to consider the country as a partner to support efforts to achieve UHC. The University of Eswatini (UNESWA) had developed a proposal for an advanced practice Master of Nursing Science in Family Nurse Practice (MNSc FNP) program and requested US nurse educators with expertise in this role to support the development and implementation of the curriculum. This would be the first master's in nursing program in the country and would introduce a new cadre of nurses into the health system.

Eswatini is a land locked country in southern Africa with a population of approximately 1.4 million people (Worldometers 2019). At the time of the partnership, the HIV prevalence in Eswatini was the highest globally (27.4%) (UNAIDS 2017) with 71% of people having TB with HIV coinfection (Kingdom of Eswatini Ministry of Health Monitoring and Evaluation Unit 2017). Eswatini's healthcare is nurse led. The country has four nursing institutions and no medical school resulting in more nurses than physicians (0.1 physicians and 1.4 nurses/midwives per 1000 people) (The World Bank Data 2019a, b). Despite a shortage of nurses and midwives—1.4 nurses/midwives per 1000 people compared to South Africa at 5.2 per 1000 (The World Bank Data 2019b), the nursing profession demonstrates cohesiveness, strength, and representation across academic institutions, the nursing council, the nursing association, and the nurse leaders within the Ministry of Health.

The FNP program offered a unique opportunity to support a nurse-led health system. Seed was confident that it could recruit qualified educators to support UNESWA's development and implement the FNP program. Seed could lend support

by sharing a framework and lessons learned for the FNP educational program and role based on the US model, work with faculty and local nursing leaders to adapt that model to the local context, and learn from nursing leaders from Eswatini regarding their keys to success in the development of the FNP program.

Over the course of our 2-year partnership with UNESWA under GHSP, Seed recruited and placed four US nurse practitioner educators who worked side-by-side with faculty to support the development and implementation of the FNP program. Together, they revised the FNP program curriculum, finalized program outcomes, developed course syllabi, and taught in the classroom settings.

This chapter provides a reflection on the partnership between Seed and UNESWA and the role of nursing leadership to effect change in the educational and healthcare systems using Eswatini as the exemplar. This chapter will explore: (1) how strong academic nursing leadership influenced the evolution of the FNP program, (2) areas for consideration when educating FNP students in Eswatini, (3) areas for consideration when mentoring and developing strong FNP faculty in Eswatini, (4) successes and challenges related to FNP program, and (5) how the country's nurse leaders prepared Eswatini for the FNP role.

16.1 Part I: How Strong Nursing Leadership Influenced the Evolution of the FNP Program

The role played by leadership in the evolution of academic programs is crucial. When developing or advancing academic programs, especially in the midst of obstacles, the strength of leadership is seen in the persistence and commitment to quality. It is essential for the relevant and right people to commit to the vision of a new academic program. Stakeholders' satisfaction with the direction in which the program is moving serves as the currency for influence and effectiveness. Four key characteristics of academic leadership emerged during the coordination of the UNESWA FNP program.

16.1.1 Leverage Relationships

Maintaining active professional relationships within and outside the academic institution is key to the success of developing and launching a new academic program. This requires knowledge of the individuals and organizations that have a stake in the program, and their views about the significance of the program to them and the community of interest. Leadership needs to develop awareness, create a shared vision, and correct misconceptions or misinformation. Being part of a small country like Eswatini, which predominantly is comprised of a single ethnic group, has its advantages. Personal and professional connectedness is strong among nurses, other healthcare professionals, educators, and policy makers. These relationships coupled with a deep cultural understanding make communication and interactions easier and more informal.

An effective leader in Eswatini understands the culture of the people and organizations, and respects individuals and protocol, which can be intangible at times. Relationship currency is a term used to describe this concept. It is what leaders need and use to advance a particular goal (Harris 2018). When developing the FNP program in Eswatini, regulatory bodies, potential clinical agencies, prospective employers, nursing education schools, potential students, and other partners participated in the process and stayed engaged with the university. Their involvement in the inception, development, and implementation of the program positively influenced its academic success and exemplifies how best to leverage relationships.

16.1.2 Integrity

It is said that ". . . integrity is the basis for social harmony and action" (Price-Mitchel 2015). Leveraging the right networks in academic leadership requires authenticity, transparency, clear communication, and being open to feedback. A high level of integrity by academic leaders is imperative to build trust and confidence for the people and organizations that wish to invest their resources and energy into supporting the program. Being principled, ethical, and culturally intelligent as a leader serves not only to demonstrate personal and professional credibility but also validates the academic institution's trustworthiness.

16.1.3 Assertiveness

Boldness and respect was an important attribute of leaders to ensure successful development of the UNESWA FNP program. It was essential for administrators, faculty, and policy decision makers to support and embrace the academic transformation created by a new program. Assertiveness as a leader involves being willing to challenge decisions that may stifle the progress of an academic program. Assertiveness may take the form of persistence and advocacy to engage administration and important committees to reverse decisions that negatively affect the intended outcome of a program. For example, faculty successfully persisted in advocating for an advanced physical assessment course in the FNP program which administration had originally removed from the curriculum.

16.1.4 Faculty Leadership

Turnover in administrative leadership can stifle the progress of new academic programs. Most academic institutions in Eswatini change leadership every 2–3 years. For example, the head of the general nursing science department at UNESWA changed in the middle of the academic year in which the curriculum was being finalized and again changed 2 years later when the first class was in the middle of the second year of the 3-year program. These rotations may result in new academic

programs languishing if new administrators do not support them although this did not occur at UNESWA. Having an efficient and effective faculty program committee established, whose members are passionate individuals committed to the success of the program, is an advantage and foundation for success. Academic leadership needs to be strategic when developing program committees to ensure that the team is comprised of people who share similar sentiments about the goals of the program.

16.2 Part II: What Does It Take to Educate Advanced Practice Nurses?

Curriculum provides a framework for an educational program and defines how well the program's graduates will meet the healthcare needs of their patients, communities, and the country. Similarly, development of clearly defined, measurable competencies serves as the foundation for the advanced practice nurse. This section describes the process used to finalize the UNESWA MNSc FNP curriculum and development of core competencies for the FNP graduate.

16.2.1 Curriculum

UNESWA nursing faculty developed a curriculum as part of the university's approval process. It was reviewed by outside consultants and feedback was used to make revisions prior to final submission of the program proposal. The approved program proposal included a 58-credit 2-year full-time curriculum with required and elective courses. The curriculum included many non-clinical courses such as human resource management, health economics, clinical teaching in nursing, research, and a master's thesis. This curriculum was consistent with the program's intent to prepare nurses to function in leadership roles in clinical education, health policy, planning, administration, and human resource development.

In August 2016, three GHSP Educators joined the nursing faculty of UNESWA to teach and contribute to the final development of the FNP master's program. GHSP Educators included an FNP with clinical expertise and 20 years of academic experience, an acute care nurse practitioner (NP), and a nurse specializing in infectious disease. A FNP program committee was created and oriented by the UNESWA faculty members to the vision, mission, and goals of the proposed program. The NP Educators contributed a deeper understanding of the FNP role and clinical nature of graduate NP programs. Through the process of consensus building, the committee created synergy between the needs of the country and a stronger clinical orientation for the program.

During the first semester of the 2016–2017 academic year, the university approved the FNP program proposal after which the committee and faculty as a whole finalized the curriculum. Examples of key updates included:

(a) A 3-year part-time curriculum was developed to eliminate the heavy burden of seven courses each semester in the first year and the need for new faculty for which there was no budget.
(b) A course on the management of mental health conditions in adults and children which originally was an elective became a core course.
(c) A clinical seminar was transformed into an FNP role course to promote professional development.
(d) An additional 100 clinical hours were added to the internship in the second semester of the last year.

An advanced health assessment course, which was included in the initial program proposal, was not approved by the university. In its place, an optional workshop was organized for the first cohort in an effort to equip them with essential assessment skills. This alternative, though temporary, bolstered the ongoing advocacy of the faculty, who were ultimately successful. This course is now a requirement of the FNP curriculum.

Faculty completed a standardized template for each course in the curriculum which included a course description, objectives, expected learning outcomes/competencies, content, teaching and learning activities, and assessment methods. GHSP Educators solicited course syllabi from NP programs in the United States to serve as examples for content, resources, and assignments. Each template was reviewed by the FNP committee for suggested revisions. The completed course templates were submitted and approved by the Ministry of Education.

16.2.2 Core Competencies

Once the curriculum was completed, a GHSP Educator helped faculty to synthesize a set of core competencies. The 2012 nurse practitioner core competencies, developed by the National Organization of Nurse Practitioner Faculties, became the organizing framework for program's core competencies and were contextualized to the country's needs and circumstances. The FNP committee reviewed, revised, and ultimately adopted these competencies.

16.2.3 Scope of Practice

A scope of practice statement adopted by a country's regulatory agency is essential to define the advanced practice nature of the FNP role and eliminate barriers to practice (DiCenso et al. 2010). This was especially important in Eswatini, which offered an FNP certificate program between 1979 and 1994 to prepare nurses to deliver services focused on health promotion and maintenance, and prevention of disabling conditions through early diagnosis and intervention. Additionally, the program prepared nurses for leadership in health planning, administration, and human resource development (Mathunjwa and Potgieter 2004). This original role, however,

was not that of an advanced practice nurse and there was no defined scope of practice (personal communication G. Msibi, June 2018). The certificate program closed due to lack of funding.

The master's program proposal included a scope of practice (SOP) to guide development of the curriculum and implementation of the FNP role. The FNP program committee compared the proposed SOP to the Washington State Nurse Practice Act, which does not require physician involvement in NP practice. Some of the proposed SOP language was revised to clarify the elements of the scope of practice and reflect the local context. For example, revision to the proposed prescribing language eliminated reference to recommending medications and stated the FNP could select, order, prescribe, monitor, and evaluate the effectiveness of drugs. Admitting, managing, discharging, and referring patients to and from healthcare facilities, and to other healthcare providers was added. Representatives of the university faculty presented the SOP to the Eswatini Nursing Council (ENC) in November 2016 and this statement was subsequently approved. The academic leaders were advocates for the program and the role. The regulatory leadership of the ENC was another example of advocacy assuring full practice authority for FNP graduates. Adoption of a SOP was an essential step to move forward creation of the FNP as an official cadre by the Ministry of Health and Ministry of Labor. The SOP also eliminated ambiguity about the FNP role as an advanced practice role.

16.2.4 Flexibility, Responsiveness, and Resourcefulness Within the Local Context

To educate FNPs in the local context requires a great deal of flexibility and responsiveness on the part of the faculty. As the FNP program was new and part-time, students were unable to receive official sponsorship from their workplace and consequently were required to use vacation time to attend classes. Faculty accommodated students by developing a revised class schedule, increased distance learning, and adjusted clinical schedules. Consequently, class attendance and clinical participation has consistently been good. The challenge of self-sponsored students also includes having no scholarships to pay tuition or purchase required materials for coursework.

Books are expensive and the university does not subscribe to most journals, hence, in order to ensure students have access to essential and current materials for study, faculty must provide assistance. For example, one professor sought grants to purchase tablets for students so that they could electronically acquire some of the required resources. Faculty have been trained on open educational resources (OER), which provide students and faculty with reliable, recent and peer-reviewed educational materials allowing them to develop information, media, and technology skills. Open Access for Africa is a project of the University of Massachusetts Boston (UMB), which provided students with access to databases to search for and retrieve any full text article available to students and faculty at UMB. Students could also register for access to certain resources such as Up-to-Date and Medscape and use

e-books and much more. Inadequate access to the Internet and limited bandwidth to view and download materials are limiting factors to using these invaluable resources.

Students also required clinical resources. GHSP funded equipment for the practice laboratory such as anatomical models for learning advanced health assessment techniques including pelvic exams, and otoscopes and ophthalmoscopes. Students were required to purchase stethoscopes and those who were unable to afford stethoscopes could borrow them from the skills lab.

Exposing students to clinical experience requires developing and nurturing relationships, especially since faculty has to work with physicians to teach APN students. In the USA, physicians were the first preceptors for NPs and, to this day, still serve in that role when NPs are not available, given the competition for preceptors. Physicians' willingness to mentor and teach students in the clinical area is commendable. These physicians do, however, require orientation to the FNP role to assure they understand the distinction between an FNP student and a medical student. The challenges with clinical placements include not having enough agencies within the desired geographic locations in a highly rural country with limited transportation.

16.2.5 Committed and Qualified Faculty to Teach the Content

The challenges of initiating Eswatini's FNP program in the twenty-first century is reminiscent of the challenges confronted by early educators such as Drs. Loretta Ford and Henry Silver in 1965. Who will create a vision of the role? Who will serve as faculty? What are the resources needed? Who will precept the students? How will the FNP be introduced to the healthcare system, the future FNPs' colleagues, and the people of the country?

Developing nursing programs is an intensive pursuit that requires not only expertise in the field, but commitment, passion, and the fervor to contribute to the transformation of the healthcare system. The FNP program in Eswatini was pioneered by faculty who were not FNPs but were visionaries who saw the need for such a cadre and wanted to transform the Eswatini healthcare system. They wanted the country's health system to thrive in the twenty-first century in spite of the devastation caused by the HIV epidemic over the past decades and the country's resource constraints. A concerted and collaborative effort by the Ministry of Health and health professional education programs is essential to produce an effective health workforce that will respond to the health needs of the population through innovation and scholarship. Educating FNPs at the graduate level can assist with developing a workforce that will meaningfully, effectively, and economically respond specifically to the population's health needs.

The UNESWA Heads of Department who especially aspired to see the FNP program established were Ms. J.V. Mdluli and Dr. T.R. Mathunjwa, who during their terms of office, pioneered and pursued this program with the support of the faculty. The nursing faculty, only one of whom was educated as an FNP, demonstrated their motivation and commitment to the success of this endeavor. This program started

with 13 students registered part-time in August 2017. Since this is the first nurse graduate program in the country, no local practicing FNPs were available to model this role to students. Faculty from other disciplines and within nursing who are content experts teach and collaborate with the one FNP educated faculty member and the visiting FNP faculty (one of the GHSP volunteers) who help align the content with the FNP role.

Faculty development and support at UNESWA often occurs with specific tasks or through individual faculty continuous professional development pursuits. For example, training faculty on blended, distance and online learning occurred through module development workshops. Faculty development in low resource settings also involves gleaning knowledge and skills parenthetically. As nursing faculty roles expand to include teaching (both didactic and clinical), community service and scholarship, finding a balance is often a challenge, especially with the increased student to faculty ratio. Since human resources are scarce, faculty who teach in the graduate program also teach the undergraduates, increasing the workload. Therefore, academic leadership needs to acknowledge faculty for their contributions and to find ways to keep them motivated and empowered. There is no funding for faculty development so few are able to attend conferences and workshops unless they are sponsored by an organization. Consequently, faculty knowledge of innovations in teaching and practice is limited and it is challenging to keep courses clinically current.

16.3 Part III: What Does It Take to Educate and Mentor Strong FNP Faculty?

Developing nursing programs is an intensive pursuit that requires not only expertise in the field, but commitment and passion to contribute to the transformation of the healthcare system. A concerted effort by both the Ministry of Health and health professions training institutions is essential to produce an effective health workforce that will respond to the health needs of the population through innovation, commitment, and scholarship.

16.3.1 Mentorship and Continued Support

As previously noted, one of the former GHSP volunteers is now a member of the faculty while local faculty pursue advanced degrees. She directs the program and serves as a faculty mentor. An adult NP who is a Fulbright Specialist Program has also assisted in teaching and provided faculty support. One of the department's goals is to further develop the competencies of the one UNESWA faculty member who was educated as an FNP in Botswana. After completing her Ph.D. degree in South Africa, she plans to develop a clinical practice as an FNP. She was sponsored by the American Association of Nurse Practitioners to attend the 2019 annual conference. From this experience and the networks she formed, we anticipate that she

will contribute to the advancement of the FNP program to prepare graduates with the competencies to practice in the twenty-first century and be responsive to local healthcare needs.

16.3.2 Recruiting Pipeline

One of the strategies that the department proposes for recruiting and training faculty for this program is to develop a pipeline of faculty and clinical mentors from the initial cohorts. This process will help to identify graduates with the potential to develop the program further. The advantage of recruiting faculty who have undergone the program is that these individuals know its advantages and disadvantages, and which aspects of the curriculum or pedagogy need further reinforcement. Graduates from the program are aware they have a huge responsibility to stakeholders, to prove their worth in the system, and the burden to set the standard for APNs in the kingdom. The graduates who understand this challenge and embrace it meet the criteria for future faculty or clinical mentors.

16.3.3 Role Modelling and Mentoring of Faculty

UNESWA faculty who developed the FNP program proposal developed an initial vision for the FNP role based on an extensive review of literature and existing FNP programs. GHSP nurse practitioner educators steeped the faculty in a deeper understanding of the contributions of the FNP as part of a team and clearly differentiated the FNP role from that of the registered nurse and the physician. The nurse practitioners provided concrete examples of their clinical experiences to bring the role to life. The two NP volunteers who served in year 2 implemented the program with the initial two cohorts of students and provided group and individual mentoring regarding the NP role through courses, working in the practice lab and as evaluators at clinical sites. They also were able to engage in clinical practice to model the role. The curriculum development process engaged faculty in assuring graduate level content was clinically relevant to the FNP role in Eswatini. The process also invested the faculty in adhering to the vision for the advanced practice FNP.

16.4 Part IV: Implementation of the FNP Program: Successes, Challenges, Next Steps

The UNESWA MNSc FNP program matriculated its first cohort in August 2017 with 13 part-time students. The second cohort of 13 students was admitted in January 2018. A third cohort started in August 2019. The first cohort will graduate at the end of 2020.

16.4.1 Successes

Great strides have been made to make the program visible locally and internationally. Creating networks, especially with local organizations and US partners like Seed, Peace Corps, and Fulbright has been beneficial in taking the program to where it is today.

Initiating clinical rotations was a challenge but the preceptors' reception to teach the students was commendable. Winning support of stakeholders and the health teams for student NP practice is considered a major success resulting from the leveraging of relationships, especially in preparation for graduates' entry and acceptance to practice. The support and willingness to precept NPs while they are students holds promise for future acceptance of this new role.

Students report that their skills and confidence are increasing. They are recognized at their worksites as nurses with advanced knowledge and co-workers are increasingly coming to them with questions. This motivates students to continue to participate in the program despite the hardships. The students who are pursuing this degree are dedicated and hardworking. They are assets to the nursing profession in Eswatini.

16.4.2 Challenges

The university requires Ph.D. faculty to teach in a master's level program, however, pursuing doctoral level studies is a challenge due to limited funding and time.

Without NPs to model the role for students and new graduates in practice, coupled with the limited number of physicians, there is a risk for role conflict and task shifting. With an expanded scope of practice, NPs are likely to be treated or viewed as physician substitutes, and there are no current NP mentors to guard against this.

Integrating technology into academia is a challenge in most parts of Eswatini. Students are registered part-time in this program with limited in-person contact time; communication is often through e-mail, WhatsApp, and MOODLE, the official learning management system, yet access to these technologies can be difficult and/or costly.

Students vary as to where and when they were educated in their undergraduate programs and where they have worked. Different levels of knowledge and skills pose challenges for didactic and clinical courses. For example, some students did not have a pediatrics course in their undergraduate curriculum whereas now this is standard. Some obtained their bachelor's degrees before HIV disease was prevalent and they may not have received training on managing people living with HIV disease. Three of the students did not receive midwifery training while some who did have not worked in women's health. The curriculum has a full credit load and therefore adding women's health content would be difficult at this time.

Most students work full time. Adding time to come to class into their busy schedules is challenging and finding the time to include clinical rotations is very difficult. Some

students have taken vacation to complete clinical requirements. Students do not have scholarships; securing the money to complete their education adds an extra burden.

One of the concerns raised prior to implementation of the program was that nurses would obtain the master's degree to advance in a job category rather than being committed to the FNP role. The government has not created an official job category for the FNP. Consequently, it may be difficult for graduates to secure employment as an FNP which creates the risk of spending time and resources for FNP education only to lose these nurses to other employment.

16.5 Part V: How Do Academic Leaders Prepare a Country for the FNP Role?

Developing the FNP master's program was only one component of the introduction of the role to the country. Seed invested in a landscape assessment of readiness to introduce the FNP role in Eswatini, which also served to introduce the FNP role to stakeholders. The assessment was conducted between August 2017 and June 2018 through a partnership between UNESWA and Seed with a UNESWA faculty member and the former Eswatini GHSP volunteer who is both an FNP and experienced academic co-leading the project. Project leads conducted stakeholder meetings in all four regions of the country along with key informant interviews and visits to health facilities. Stakeholders and key informants included community members, nurses, physicians, and policy makers at the Ministry of Health, Nursing Council, and professional association. Fourth year UNESWA nursing students identified as leaders in their class were invited to participate as a strategy to introduce them to the FNP role and encourage them to consider applying to the program after graduation.

Across the spectrum of stakeholders including community members, nurses, physicians, and policy makers, there was general consensus that the FNP would fill an important gap in healthcare delivery in Eswatini and that they should work in communities of need. Stakeholders anticipate the FNP will improve access to care; provide holistic, high quality, safe care; help reduce waiting times; reduce unnecessary referrals; reduce cost; improve culturally and linguistically congruent care; and strengthen the role of practicing nurses and physicians. It will take time and a concerted effort among the healthcare sector, education sector, and public policy sector to implement this role in an effective manner.

Recommendations fall into two strategic areas: strengthening the UNESWA FNP program and facilitating the successful deployment and integration of FNP graduates into the Eswatini healthcare system. Project leaders made recommendations to UNESWA's faculty to maximize role facilitators and minimize role barriers.

1. Strategies to strengthen Advanced Practice Nursing education
   (a) Add a health assessment and clinical decision making course to the curriculum
   (b) Emphasize clinical practice, decision making, and collaborative care in the FNP curriculum

(c) Include content and mentoring around the consultant role domain so that graduates feel confident serving as consultants
(d) Orient physician preceptors to the FNP role
(e) Require that students pass a comprehensive written and clinical examination at the end of each internship semester until a national licensing exam is feasible
(f) Design the monitoring and evaluation course to prepare FNPs to evaluate the effectiveness of their practice
(g) Identify sources for scholarships, travel, and lodging support for clinical experiences
(h) Partner with MOH and non-governmental organizations (NGOs) to provide internet access to students

2. Strategies to facilitate the successful deployment and integration of FNP graduates into the Eswatini healthcare system.

Stakeholder awareness of the role

(a) Stakeholders including nurses, physicians, students, community members, managers, and government officials should receive information about the FNP role on an ongoing basis and have an opportunity to develop an understanding of the role.
(b) Place students for their internship course in health facilities where they are likely to be deployed.
(c) Students in the program should share their experiences with work colleagues.
(d) Prior to deployment of the FNP graduates in 2020, the MOH, UNESWA, and the FNP graduates should facilitate a meeting with the community and health professionals to introduce the FNP to the health facility. Emphasize the collaborative nature of the role.
(e) The MOH in collaboration with the university and healthcare facilities should consider establishment of a one-year-long transition to practice FNP residency program that supports the successful integration of the new FNP graduate into the role.
(f) Improve technology resources at MOH computer centers for access to electronic resources.

Provide education, resources, and support

(g) FNP graduates will need ongoing professional development in order to successfully implement this new role and stay current with new evidence.
(h) Additional support and partnerships for the FNP program and role introduction and development would help sustain the program.

Evaluation of outcomes and impact of the APN role and new model of care

(i) A plan to monitor and evaluate implementation of the FNP role and model of care should be developed to determine feasibility, success, and challenges observed in implementing the role in Eswatini.

A plan to monitor and evaluate the outcomes of FNP care should be developed to determine the impact of the FNP on health outcomes. Determining the impact of FNP on healthcare in Eswatini will require long-term monitoring.

16.6 Conclusion

A number of challenges are anticipated, especially as the first cohort will graduate in 2020. The most pressing concern is that without existing FNPs in the health system, the pressure rests on new graduates to deliver quality care and prove to the nation, the ministry of health and clinical agencies and clients who they are and how they fit in the system. A one-year transition to practice program has been recommended to support and mentor graduates, scaffold them as they take on this responsibility until there is a strong pipeline of FNPs to mentor the following generations.

The termination of GHSP and our partnerships in 2018 was unanticipated and came about swiftly. It prompted Seed to undergo a deep strategic planning process, which brought us to a new strategic plan, *Sharing Knowledge and Saving Lives: Seed Global Health's 5-Year Strategy to Strengthen Health Systems.* Our partnership with Eswatini had been put on hold; however, Seed has conducted a landscape assessment and feasibility study to assess the opportunities and the operational requirements to resume our partnership independent of the GHSP infrastructure. In the meantime, Fulbright and Peace Corps have been supporting UNESWA with non-clinical US faculty and opportunities for capacity-building. Seed's unique value is our ability to place educators in the clinical and classroom settings and we are making progress to hopefully continue our partnership with Eswatini and UNESWA in the near future.

The introduction of the FNP disrupts the status quo of an entire health system. It challenges physicians and nurses to re-evaluate their roles; it challenges the ministries to consider how to absorb and distribute and pay for this new role; it challenges education systems to build the capacity of their faculty. Nurse leaders in Eswatini have leveraged relationships and have demonstrated integrity, boldness, and a vision to improve access to quality care through creating the FNP role.

The future holds numerous opportunities and challenges for nursing leaders, especially among the FNPs. Implementation of the FNP role will provide Eswatini with a readily available workforce well prepared to manage common acute and chronic problems. This will decrease reliance on recruiting physicians and allow physicians to focus on hospital-based and specialized care. FNPs and physicians can transform the healthcare system as they develop a collaborative care model which emphasizes respect for interprofessional, team-based care. As research has shown, FNPs have an opportunity to demonstrate the power of a pioneering spirit, ability to work independently, curiosity and willingness to shape one's own practice (Lovink et al. 2017). Nurse leaders must be prepared to overcome challenges such as physician reluctance to share the responsibility of patient care (Lovink et al. 2017). Assuring the government establishes a job category for the FNP and actually hires them is another important challenge for nurse leaders to assume.

The success of Seed and its partnership with UNESWA was possible because of the inherent strength of nurse leaders in Eswatini. As this chapter's UNESWA faculty contributor aptly states, "Our culture assists us in our success. Rather than being individualistic, it is the personal relationships, which promote success.

Nursing leaders go beyond nursing; they develop personal relationships with their colleagues in the ministry, universities, associations and councils. It is to some extent that which determines how the process gets implemented (Colile Dlamini, oral, June 19, 2019)." It is this deep alliance of nursing leaders across key sectors that advocates for and galvanizes change so that the citizens of Eswatini can live healthier lives.

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Part V

Clinical Leadership

This section focuses on what it takes to be a leader in clinical and community settings. The first chapter focuses on this kind of leadership which must include an understanding of how to work on an interdisciplinary team and how working with others can ensure great patient outcomes and improve care in the clinical setting. The concept of networking is also emphasized building from deep clinical knowledge to a shared focus on care and cure of patients. A vital part of this process is understanding that each other's practice, identity, and drives are crucial to reflect on for becoming a leader of a network.

One chapter particularly focuses on Advanced Practice Nursing leadership in France, a country with a fairly new APN role. Among the challenges is leadership development when a career ladder is a predominant mechanism for advancement versus more lateral clinical leadership in which expert clinical practice is seen as an end in itself.

Finally, a chapter is included on clinician well-being and its importance in promoting better outcomes for patients and clinicians alike. A sense of well-being has emerged as a significant factor affecting a clinician's ability to engage in the care of patients. Both patient outcomes and individual health rely on clinicians experiencing professional fulfillment through meaningful work in a supportive environment along with having the ability to cope with anticipated daily stress. This section addresses the emotional toll of caring for people and the increasing burdens on workload for clinicians, which have fueled an epidemic of burnout that threatens to harm patients and drive advanced practice professionals from their chosen work. When advanced practice nurses address work environment concerns with their organizational partners and team and adopt practices that reduce stress and foster resilience, they can maintain or restore joy in work.

Creating Strong Clinical Networks

17

Petrie F. Roodbol and Jeroen W. B. Peters

"When spider webs unite, they can halt even the lion"
Old African proverb

17.1 Introduction

Worldwide healthcare systems are transforming and in transition. Each continent or part of the world follows its own dynamic. In general, healthcare systems evolve from classic reactive disease-driven models toward more proactive bio-psychosocial models, which increase cohesion between cure and care, health care, and welfare (Committee Innovation Health Care Professions & Education 2016). Increases of chronic diseases, aging, and also the need for easy accessibility and cost effectiveness are catalysts for these reforms. Innovative technologies and extended knowledge help us to realize solutions. The new healthcare systems are multidisciplinary and interdisciplinary collaboration is necessary. Professional health networks serve patients from a holistic point of view without borders of different organizations and/or systems. In these professional networks, the nurse practitioners with their broad scope of practice in care and cure but also with competences to innovate healthcare practice may function as key team members.

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Networking is defined as the act of making contact and exchanging information with other people, groups and institutions, face to face or electronically, national and internationally to develop mutually beneficial relationships. Effectively, networking enlarges a persons' sphere of influence and helps to develop fame and a reputation (Goolsby and Knestrick 2017). It is easier to get attention as a group of nurse practitioners than as an individual.

Formal networks take the form of committees, coalitions, teams, and consortia of people who come together to share information, collaborate, and plan strategy regarding mutual issues like taking care of a specific group of patients: a clinical network. Formal networks open doors to new opportunities and lead to shared resources that ensure a competitive edge in the organization (Carroll 2005). When the different professionals of the organizational architecture and patients are working together to improve the quality of care based on the best evidence, we speak of learning networks.

Informal networking is a strategy that takes place behind the scenes and allows for contacts who speak a similar language, share viewpoints, and offer support and feedback at critical times (Carter and Reed 2019). Knowing the right people may advance a person further in his career. A well-known example is the social medium network: Linked In.

In this chapter, we will focus on how nurse practitioners can create strong clinical networks.

17.2 The Core of the Nurse Practitioner

Nurse practitioners are independent professionals offering integrated treatment to patients based on clinical reasoning in complex care situations, ensuring continuity and quality of treatment, and supporting the care recipient's autonomy, control-taking, self-management and empowering him or her within the patient's journey (Kappert and de Hoop 2019; Tracy and O'Grady 2019). They see patients as a partner: "*where the patient is considered a caregiver of herself and, as such, a genuine member of the treatment team, endowed with competencies and limitations just like any other member of the team"* (Karazivan et al. 2015, p. 438). Patients make their own choices under the condition of understanding one's health situation including prognosis, the nature of the recommended care, the risks and benefits of each alternative.

Nurse practitioners are T-shaped professionals (Tracy and O'Grady 2019); focused on a specialization in one area of direct patient care (the vertical beam may be different between nurse practitioners) but also they are competent to bear other responsibilities and tasks in healthcare (the horizontal beam, equal for all nurse practitioners). Their general roles include, among others, the roles of collaborator, communicator and the role of quality of care organizer. "*The nurse practitioner collaborates and communicates with other health professionals on the basis of equality as an independent practitioner with the objective of realizing optimal patient care* (Kappert and de Hoop 2019, p. 19)".

Collaboration and communication among colleague nurse practitioners, physicians, RN's, patients, and insurance companies are requirements for strong professional healthcare networks. Collaborative partners of different disciplines will have different perspectives and dynamics as well and we will discuss them in the next paragraphs. But first, we will take a look at the competence of the role of organizer of quality of care improvements (Fig. 17.1).

17.2.1 Nurse Practitioner as a Quality of Care Organizer

The nurse practitioner coordinates and reorganizes care processes to improve the availability and continuity of healthcare facilities (Kappert and de Hoop 2019). Examples include reducing waiting times, increasing cost effectiveness and development of new forms of healthcare, and an innovation by nurse practitioners in wound care in the community.

All Dutch residents have a compulsory basic insurance package, which covers the bulk of essential care (Ministry of Public Health, Welfare and Sport 2016). Everyone is required to register with a GP primary care provider, who as acts as "navigator" and "gatekeeper." In general, hospital care is shifting to primary care. The GP is responsible to control costs by limiting specialist referrals. The emphasis of the health care facilities lies on home health care, also for the elderly. In the Netherlands, up to 95% of the elderly are living independently at home with the help of homecare services. One of the healthcare problems of older people is chronic wounds with a prevalence of 4.5% (Sillevis Smitt et al. 2014) with physical, social, emotional, and economic consequences.

Community nurses and home-helpers are increasingly challenged to take care of these patients with complex wounds, but with no uniform wound care policy, outcomes were insufficient. Three nurse practitioners took the initiative to organize a new kind of wound-care service in the community and took the responsibility for the chronic wound care patients in the north of the country. Based on extended physical, psychological, and social assessments, they developed wound-care plans, which

Fig. 17.1 T-shaped professional

can be provided by the community nurses. The nurse practitioners follow the wound healing by videos, validate wound measurement instruments, and adjust the care plans when necessary based on their findings and their evidence-based knowledge. They also give instructions and lessons about wound healing to increase community nurses' skills. The time for wound healing and materials used were reduced by more than 50%. Based on these results, community care and insurance companies are now willing to pay for these services. Based on this success, these nurses extended their activities to long-term care institutions. They link community care and long-term care, which means a new form of care with consequences for the insurance companies.

One of the superficial success factors of this innovation is the home visit by the nurse practitioners. By looking behind the front door they get more familiar with the patients and can provide tailor made advice and as a consequence, adherence increases. Nurse practitioners bring a more holistic view and are also able to apply their general knowledge of technical developments, healthcare systems, and policies. They saw the poor quality of wound care in practice and analyzed the origin. Based on this expertise, the way they presented this finding in their plans, the involved medical specialists and GP's were easily convinced that NPs were capable to take over the care of their patients.

The nurse practitioners showed their clinical expertise and their leadership capacities. By following the innovation with research, NPs also could bill their services to the insurance companies. They were aware of the political view and need to bring more flexibility into the healthcare system. As a result, Dutch nurse practitioners have a legal independent status and are allowed to prescribe.

Another example of redesign is the outpatient clinic for breast cancer patients:

One in eight Dutch women gets breast cancer. Holland has an extended population screenings program for early detection. When after a screening the findings are suspected to need follow-up, a woman used to contact her GP for referral to a surgeon for examination and tests. Including waiting time, the whole diagnostic procedure took several weeks. However, the current norm is only one day, including possible mammography, puncture, biopsy, echo, bone scintigraphy, or tomography. This process is mainly realized with the help of nurse practitioners in the lead in the hospitals' outpatient departments for mamma care. They take care of every new suspected breast cancer patient and schedule them for all potential tests on the same day. They created a network organization with radio diagnostics departments, with pathology labs and other healthcare workers to realize this service. They perform procedures like punctures by themselves.

They could organize fixed times for consultation so that it became possible to make reservations for these patients in other departments as well. The first nurse practitioners who started the 1-day diagnostic procedure for breast cancer patients had a strong need (vision) to improve the care for this patient group. They had the knowledge of the often-compartmentalized hospital organizations with a lack of collaboration, but no unwillingness to change.

What are the success factors for this innovation? The nurse practitioners saw the anxiety and fear of these patients when they needed to wait on the results of the

tests, knowing that 70% with suspected findings discovered during the population screening that they had no cancer at all. In contrast to the surgeons with a great variety of patients, the nurse practitioner only takes care of breast cancer patients and no other types of patients. *They negotiated with insurance companies to skip the GP visit so that patients can come directly to the nurse practitioner mamma care.*

Nurse practitioners are educated in redesigning care processes in a process-oriented manner, to translate their vision into concrete actions, financing, and advising management. That is why a nurse practitioner needs to be T-shaped educated and functioning. The combination of expert-knowledge (a form of power) and generic competencies provide them with a strong position in healthcare and networks. The effectiveness of a nurse practitioner position will be dependent on the changes realized in the work structure. The resulting structure should fit the task characteristics of the service demanded by the specific group. Successfully implementing a nurse practitioner role means a change for all professionals involved (Roodbol 2005), for not only the direct colleagues of a team, but also the manager, who is responsible for a lean organization.

17.2.1.1 Example of Added Value of a Nurse Practitioner in a Transplant Network, Indoor and Outdoor Hospital Care

One of the Dutch University Centers is celebrating 50 years of organ transplants (kidneys, liver, lungs, and heart). In the beginning period of transplantation, it was a huge operation, a purely medical masterpiece with half the hospital involved (Van der Sluis et al. 2019). The pioneer period is over and posttransplant patients are survivors with new problems, like psychosomatic problems (post-traumatic stress), aging, and obesity. The current research focus is on lifestyle and not the transplant techniques or antirejection medication anymore.

Nurse practitioners play a key role in the transplant teams. They keep contacts with patients during the waiting period, keep them posted about the results of their tests, educate patients and their families, and care for patients during their post-surgical period in the hospital and the period after discharge. They monitor the medication regime, order regular tests, and set up lifestyle programs. NPs are also a source of information for other healthcare providers who get involved with transplant patients. Examples include in obstetrics when transplant patients want to get pregnant, or traveler advisement when transplant patients want to visit less developed countries or tracking of GPs' referrals to other medical specializations when patients have other health problems.

In the very beginning of the transplantation medicine period, this progress seemed to be impossible. But progress has been made in operating techniques, interpretation of test results, antirejection medication, and as a result, transplantation is partly routine care now. Like in the case of breast cancer, patients' logistic procedures are important for smooth processes.

Realizing smooth and optimal services are challenging for nurse practitioners. After the first consultation with the internist and surgeons, nurse practitioners become the first point of contact for transplant patients. They are involved in all

phases of the patients' and family care. Beyond healthcare for transplant patients, NPs are also involved in related social care. When problems are beyond their scope, like problems of employment, social workers or others on the healthcare team may be involved, but the nurses stay in contact with the patients as case managers.

Nurse practitioners are known for their cultural competence. Psychiatric nurse practitioners are competent to advise other healthcare professionals in the case of mental problems. Some patients are refugees, victims of torture, or suffering from post-traumatic stress syndrome (PTSS). Competence is important to reduce health disparities and to improve accessibility to healthcare facilities. It involves not only awareness and acceptance of differences like lifestyle, coping strategies, the level of health literacy but also communication and interaction.

17.2.1.2 An Example of Nurse Practitioners in Psychiatry

The Netherlands recognizes two legalized specialties for nurse practitioners: somatic care and mental care, both with a great variety of subspecialties. *The roles and responsibilities of psychiatrists, psychologists, therapists, registered nurses, and nurse practitioners in psychiatry are still not established. Nevertheless, in 2009 psychiatric nurse practitioners were legalized to be first practitioners or coordinating practitioners of mentally ill patients as well.*

Based on their specific knowledge, psychiatric nurse practitioners can treat patients of different categories of mental illness: in clinical outpatients and emergency rooms and in consultative psychiatry. As the aging population and patients with deliria are increasing, nurse practitioners can advise on their care. But consultative psychiatric nurse practitioners are also involved with patients with suicide attempts and psychotic, aggressive, addicted and depressive or anxious patients. They set up their own consultative services in hospitals available 24/7, for hospitalized patients but also for patients in the ER.

17.2.2 Nurse Practitioners in Leading Positions

To get and to stay in a leading position it is important to keep ahead in developments; keep up with relevant professional literature and interpret evidence-based research results on aspects of reliability, validity, and applicability. Another very important factor of success is the courage of the nurse practitioners in these cases to take the entire responsibility of a patient group (wound care, breast cancer). The NPs were experts in their subspecialty already and by showing their expertise, physicians were willing to task shift.

Practically speaking, the nurse practitioner has a strong position in the clinic. In contrast to interns and residents, nurse practitioners are constant factors since the outpatient department is their usual location. Physicians work in more locations in the hospital: wards, operation-rooms, scope rooms, outpatient departments; they are visitors, hoping that the organization is optimal. Having just one work location makes nurse practitioners feel responsible for a smooth autonomous organization. They want to reduce waiting times and shape a good atmosphere and are trained

how to influence boards and policymakers. They need to know the current policy and the problems they are wrestling with so that it is possible to respond quickly when relevant.

A strong vision, which in clear unambiguous language, is necessary. It makes sense to meet members of the board or politicians (like informal moments or receptions) to ensure that they hear about the innovation from another, more neutral person as well. In contrast to most managers, nurse practitioners are working in direct patient care and understand the work organization. They know very well what happens in the workplace, which is important to gain in a leadership position. Collaboration is, as we will see, built on trust.

To create strong clinical networks nurse practitioners must be T-shaped educated; they need to be an expert in healthcare and have broad general competences like a quality of care organizer, collaborator, and communicator. For a successful innovation the nurse practitioner needs to have a clear vision of the desired situation, competences in process redesigns, knowledge of healthcare structure and policies, abilities for out of the box thinking, but also for taking the responsibility and knowing how to influence policy makers and board members. In contrast to medical residents, they can offer continuity and therefore they are in a natural position to become a key figure in a service.

Once a nurse practitioner has taken over tasks or has developed a new type of healthcare facility, continuity must be guaranteed to be a trusted partner. Unfortunately, any mistake made by a nurse practitioner, a relatively new healthcare provider, will be magnified by opponents. Reflection and learning from experience in order to improve performance is key.

17.3 Collaboration and Communication

The variability and complexity of healthcare requires collaboration and communication skills with other healthcare professionals. During multidisciplinary work, each discipline keeps its own professional role and perspective. During interdisciplinary work, professionals are trying to combine their roles and knowledge to develop new knowledge. Multi- and interdisciplinary work is daily practice, however most educational programs are monodisciplinary. Interprofessional professional education (IPE) refers to occasions when students from two or more professions in health and social care learn together during all or part of their professional training with the object of cultivating collaborative practice for providing patient-centered care (WHO 2007). Unfortunately, IPE is still rare. While effective, IPE seems hard to organize and does not have always the interest of students and teachers. Multiprofessional training is easier to accomplish because teams are trained in collaboration for well-described acute situations keeping their own roles.

Collaboration is important and needs to be learned in practice. Working together does not mean collaboration. “Collaboration is a dynamic, interprofessional process in which two or more professionals make a commitment to each other to interact authentically, and constructively to solve problems and to learn from each other

in order to accomplish identified goals, purposes, or outcomes. The individuals recognize and articulate the shared values that make this commitment possible (Carter and Reed 2019, p. xx)." The nurse practitioner must be able not only to take into account the different perspectives of colleagues, care recipients, and relatives (Kappert and de Hoop 2019), but also the context and working environment as these may promote or hinder collaboration. The Nurse practitioners' main partners are physicians and nurses.

Working with physicians means understanding their scope of practice. Traditionally, the focus of the physician is dualistic and is focused on the illness or disease itself. When the diagnosis has been made, mostly an intervention or treatment is performed. The classic medical way of thinking is more or less linear: assessment, diagnosis, treatment/intervention, curing. Physicians' communication style is to the point and their feedback style direct. Nurses are more inclined to narratives and indirect styles. This difference can be a source of irritation caused by the different foci. In the diagnostic procedure, the physician does not want to be distracted. Nurse practitioners are somewhere between nurses and physicians. They need to make medical (and nursing) diagnoses as well but have a more holistic view and want to be informed broadly to get a complete picture of the patient.

Working with nurses seems easier, but in some situations the acceptance of the nurse practitioner role by nurses can be challenging. This can be explained by the theory of social identity (David 2015). People derive their social identity from the group to which they belong. Who am I and who am I in relation to others? What do I have in common and in what way I am different? People aspire to have a positive social identity, which is based on favorable results of comparison with the group they belong. The central hypothesis of social identity theory is that group members of an in-group will seek to find negative aspects of an out-group, thus enhancing their self-image. An individual can try to become a member of an out-group with a higher status but needs to be accepted. A nurse practitioner may be seen as someone who is leaving the nursing group and joining the group of physicians.

Gender and stereotypical images of health professionals are barriers for collaboration. Traditionally, physicians used to be male and nurses female. Although nursing is an independent profession, a semi-hierarchical relation still continues to exist between the medical and nursing professions. This is based on the stereotype of nurses as handmaids and not as independent bachelor- or master-educated professionals. Oostveen et al. (2015) found that the nurse's position in the hospital is often subordinate to managers, policy makers, and the medical discipline.

It is our premise that nurses who do not adopt nurse practitioners is professionally risky. By not accepting, nurses take the risk that nurse practitioners will form a new group with a non-nursing identity, which will more or less subordinate nurses (Roodbol 2005) as well like physicians. Also, the image of nurses is increased by the introduction of the nurse practitioner and by not adopting the new role nurses will lose this chance to further advance as a profession.

Teamwork starts with trust. Knowing and understanding is needed to build this trust, just like recognition of individual strengths and weaknesses and respect of

differences in motivation drives. Vulnerability is not a weakness; it shows your honesty and is a building block of trust.

Reciprocity is a social norm of responding to a positive action with another positive action, rewarding kind actions. Easy accessibility to all network members advances reciprocity, as much as multi-stratification, seeing each other in different situations, including informal ones. Use a variety of communication tools to increase communication. The nurse practitioner needs to have knowledge of various communication theories (content, procedure, process) to communicate effectively with other professionals, apart from the required skills for communication with patients. They need to know the world of the recipient of their messages to adjust their style when necessary. Communication has to be concrete, complete, and clear (Mulder 2012).

Just because collaboration needs to be learned in practice, it important as a professional to reflect on the way he or she is acting on a regular basis. This means thinking on a deeper level, questioning on assumptions, gaining greater self-awareness. As a leader of a network, nurse practitioners should be capable of discussing the mutual collaboration of a team and of making suggestions for improvements to realize an optimal working network for excellent patient care.

17.4 Tools for Collaboration and Reflection

In collaborative practice, the nurse practitioner self is a tool. This means knowing yourselves and the capability to reflect on the work situation.

It is important to understand another person well to realize effective collaboration. However, this is not easy. Our drives, feelings, and thoughts all play a distorting role (Covey 2013) in understanding another or in the assessment of oneself and the situation. Sometimes this may lead to projection of our feelings and thoughts on the other. This process interacts and as long we are not aware of this, we are not capable of seeing another's persons view and to understand.

The model of Dilts and Bateson makes all perspectives visible, which influence choices, conscious or unconscious. This model supports for reflection as well (Fig. 17.2).

The model shows potential influencing and interacting factors, like written and unwritten rules, patterns, culture, but one's also own beliefs and values, professional capacities and involvement. Reflection aims to make implicit choices explicit so that learning becomes possible.

In practice, reflection stops at the evaluation: did I do it right? This is the first level of reflection as suggested by Argyris and Schon (1974). They identify three distinct levels of reflection and together with the Dilts and Batesons' (1972) questions, a complete picture of the situation arises (Fig. 17.3).

In a single loop reflection, the central question is: "what am I doing and what I am allowed to do, and did I do this right?" Reflection on this level consists of the development of new behavior by adapting to the situation. Double loop reflection

Fig. 17.2 Dilts and Bateson

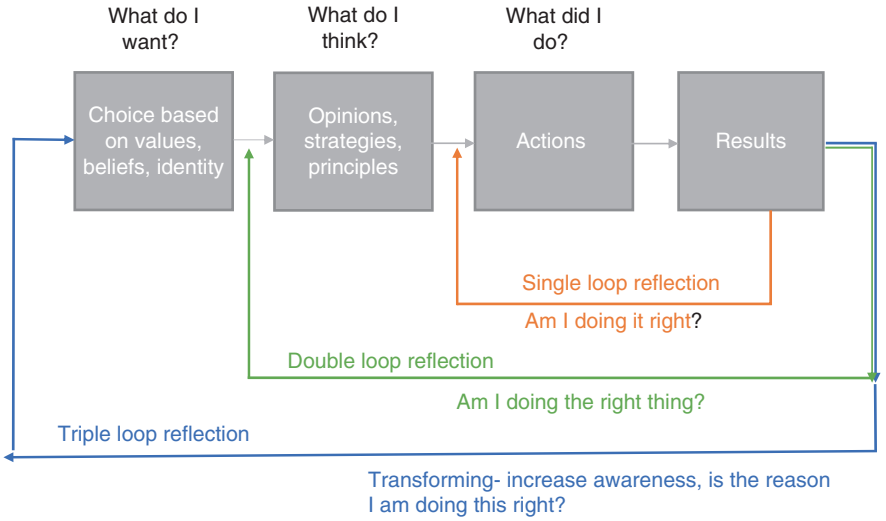

Fig. 17.3 Argyris and Schon (1974)

means thinking over the underlying thoughts and motives of the rules and regulations and coming to new understanding, insights, and behavior. The professional understands why he or she acted like they performed.

In triple loop reflection the central question is: "am I doing the right things with the right motives?" To answer this question essential personal principles, values, and beliefs need to be reconsidered. "Who do I want to be? Do I really want to be involved and responsible?" This kind of reflection requires courage and is inevitable for good leadership. The third level of reflection leads to real, essential changes.

Realizing triple loop learning in the work environment asks collective reflection as well. The inter- or multiprofessional teams jointly need to answer the question, "who are we and where are we stand for." Organizational mission statements and reports are often too general to formulate a joint horizon that supports specific team functioning. By discussing the identity and values, a team will become more cohesive and the members will show reciprocal behavior.

To summarize, collaboration asks team members to understand each other. Therefore, it is important to know yourself and to understand your reactions and behavior in contact with others and in your work environment. In collaboration, the nurse practitioner becomes the tool. Awareness of personal and professional beliefs, values, and reaction patterns are necessary, as well as self-knowledge and recognition of the context and perspectives. Reflection is an important tool to collaborate and to realize effective clinical networks, with optimal patient-centered care.

17.5 Conclusion

Collaborative work in professional networks is necessary to improve the quality and accessibility of the current healthcare system. Nurse Practitioners are in the position to serve as leaders of these networks. They are capable of redesigning care in a process-oriented manner to translate their vision into concrete actions. Collaboration and communication with colleague nurse practitioners, physicians, RN's, patients, and insurance companies are required. Therefore, nurse practitioners need to be expert in healthcare and to have broad general competencies like coordinating quality of care, collaboration, and communication. In collaborative practice, the nurse practitioner's self is a tool. This means knowing yourselves and the capability to reflect on the work situation.

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APN Role Implementation: An Opportunity to Reconsider Clinical Leadership in France

18

Christophe Debout

18.1 Introduction

Leadership is a key concept in the international nursing literature (Cummings et al. 2008). Nursing leadership has been identified as essential to achieving the often-ambitious objectives set for healthcare professionals in the contemporary health context. However, according to the international GLOBE study (House et al. 2004), the generic concept of leadership is approached differently from one country to another depending on cultural factors. The influence culture plays on leadership is also observable in the field of health and nursing.

The way the concept of nursing leadership is approached in France is unique as it is most often assimilated to that of management. Consequently, leadership is often perceived as the exclusive domain of managers. However, French clinical environments are subject to many reorganizations. There is a need not only to increase the individual and collective performance of multi-professional teams (Askenazy et al. 2013), but also to work towards the development of more positive practice environments for health professionals in order to improve their quality of life at work (Ministère des Solidarités et de la Santé n.d.-a).

In this context, the recent decision to introduce advanced practice nurses (APNs) into the French health system and to encourage them, in addition to their clinical activities to demonstrate clinical leadership within their team, constitutes a major paradigm shift at the national level. For the first time in history, the term "clinical leadership" is used in a policy governing nursing practice in France (Ministère des solidarités et de la santé-Ministère de l'enseignement supérieur, de la recherche et de l'innovation 2018). It is therefore necessary to explore the context in which this

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decision was taken and to anticipate how this change will be operationalized by the first French APNs who graduated in the summer of 2019. It is urgent to adopt effective strategies to address the potential challenges that will be encountered by this new category of nurses in developing their leadership to the benefit of patients, healthcare teams, and the health system (Debout and Hue 2019).

At the end of a brief description of the French health context, the challenges that the health system is facing now will be presented highlighting the unique strategies implemented in France to address them in terms of nursing leadership. The missions assigned to the advanced practice nurse in French legislation will be presented, more specifically in the matter of clinical leadership. The results of a SWOT analysis will guide the formulation of recommendations designated to promote an effective deployment of the first APNs and the development of their clinical leadership to achieve positive outcomes.

18.2 Health and Nursing: The French Context

France is characterized by universal health coverage (UHC) which has been provided to its population since the end of the Second World War (Chevreul et al. 2015). While UHC is a major asset for the population, as highlighted by the World Health Organization in 2000 (World Health Organization 2000), it is more and more difficult to preserve it in the contemporary health and economic context. Since the late 1990s, the health sector has opted for a governance model inspired by the new public management principles (Simonet 2014) .

A few years ago, an ambulatory shift was initiated to move away from a system that had previously been too hospital centered and to better control costs. This change has resulted in a reduction in the average lengths of stay of patients in hospitals and a transfer of burden to the community (Askenazy et al. 2013; Chappoz and Pupion 2014).

The French healthcare system is also characterized by the primacy given to the curative approach of the disease. Therefore, health promotion and prevention need to be improved. This observation is a source of concern considering the demographic and epidemiological characteristics of the population living in France. The population is aging, and the prevalence and incidence of chronic diseases are constantly increasing.

In France, home care is mainly provided by private practice physicians and health professionals, including nurses, who are in contract with social security. These professionals do not practice necessarily in the same place and do not constitute a classical healthcare team. The hospital nursing organization models remain relatively fixed in France. A team approach was introduced in the 1980s, but more recent models, such as primary nursing for example, are rarely implemented except in psychiatry.

Professionals and many professional organizations deplore the perverse effects produced by the implementation of the new public management principles in the health field; practice environments are becoming less and less favorable to nursing practice. The nurse/patient ratio continues to increase in order to obtain more productivity gains. Evidence from the work of Aiken (Aiken et al. 2008) and the RN4cast consortium (RN4CAST n.d.) are not considered in governmental decision-making processes. The outcomes addressed to French healthcare professionals are more and more ambitious. They can be summarized in several injunctions: do more, do it faster, do with less and do not alter the quality and safety of care. These injunctions seem paradoxical, and their implementation generates many adverse effects: the quality of life at work of healthcare professionals is decreasing and psychosocial risks are increasing. A national observatory has recently been created to address this phenomenon (Ministère des Solidarités et de la Santé n.d.-a). However, it is not only the symptom we need to treat adequately, but also its etiologies in order to reduce the high turnover observed in teams.

In addition, there is poor distribution of medical care in the community in France. The concept of "medical deserts" is now observable in a growing number of regions, especially in rural areas (Vergier et al. 2017). This phenomenon is multifactorial. First, a *numerus clausus* is used to limit the number of students admitted each year in the second year of medical studies (Attal-Toubert and Vanderschelden 2009). Second, the maldistribution of physicians in the country is the consequence of the total freedom given to new graduates to choose where they would like to practice. Even the medical education physicians get in public universities is largely subsidized by public funds and they are not obliged to contribute to the promotion of access to medical care. Most physicians prefer to work in urban zones leaving people living in rural areas without adequate access to medical care. Moreover, the medical profession is becoming more feminine in France and physicians now aspire more to a salaried practice in order to preserve their quality of life (Barlet and Cavillon 2011).

A shift towards ambulatory care that has been initiated, combined with the medical desertification of certain territories, creates a lack of community care and an engorgement of emergency services, leading to strikes that received widespread media coverage in 2019 (Cour des Comptes 2014).

France has more than 600,000 nurses, most of whom work in the public sector. Males constitute twelve percent of nurses who work in this profession and this figure remains stable over time (Debout and Hue 2019). There is only one level of nurses in France, before 2009 they were educated at diploma level. In 2009, the national standard curriculum was upgraded and since 2009 registered nurses are educated at the bachelor level.

The French nursing context is characterized by one particularity: currently France has no nursing shortage. This situation is the result of an increase of more

than 40% in the number of nursing students admitted to nursing training institutes in the early 2000s, as well as an increase in the nurse/patient ratio. However, this balance remains precarious in view of the age pyramid of nurses and the increasing needs of the population in nursing care. It is therefore essential to increase the attractiveness of this profession and its retention in order to effectively face the challenges ahead.

18.3 National Health Challenges Like Those Faced by Many Countries

This brief overview of the health situation in France and the characteristics of its healthcare system highlight the public health challenges that the country faces: maintaining access to care, seeking the relevance and effectiveness of interventions implemented by health professionals, maintaining the quality and safety of care, and seeking efficiency and individual/collective performance of healthcare professionals. These challenges drive the decisions of public policy objectives in the field of health. Many of these challenges are like those faced by other countries around the world.

Many countries have chosen to promote the development of nursing leadership, at all levels, as part of the strategies developed to meet these challenges.

Many authors have proposed definitions of leadership (Cummings et al. 2008; Bass and Stogdill 1990; Day and Antonakis 2012; Stanley and Stanley 2018; Curtis et al. 2011). Commonalities can be drawn from these definitions:

- Leadership is an interpersonal process that takes place within a group.
- It is based on a bilateral transaction between a leader and his "followers."
- This process is usually initiated, in a more or less conscious way, by the leader.
- Leadership is the means by which a group achieves a common goal that it has set for itself or that has been assigned by a third party.

Scientific publications are numerous on this topic. When the keyword "nursing leadership" is entered into the Pubmed® database, 15,671 references were retrieved (search performed in June 2018).

The first reference including the keyword "nursing leadership" appears in the database as early as 1946 and its occurrence increases sharply since the end of the 1990s with a peak in 2016 (946 references).

The studies carried out to assess the impact of nursing leadership show the benefits obtained from implementation of an effective leadership at different levels: professional leadership exercised by professional organizations, managerial leadership implemented by managers, and clinical leadership observable among health professionals. When a synergy exists between these three levels, positive

results occur. The main benefits attributable to nursing leadership can thus be derived from these studies (Cummings et al. 2008; Roussel 2019; Shamian and Ellen 2016):

– Improved patient outcomes and safety
– Positive practice environments
– High satisfaction of healthcare professionals
– Reduced turnover in healthcare teams
– Benefits for the organization

Considering the benefits that could be obtained, it would seem logical for health systems to make the development of effective nursing leadership a priority. However, some countries seem not to adopt this strategy. France falls into this category.

18.4 A Unique Reading of the Concept of Leadership in France

The GLOBE study investigated 17,300 middle managers from 951 organizations in 58 countries to identify from a generalist perspective, how the concept of leadership is understood in different cultures. The framework used in this study articulates nine cultural dimensions (House et al. 2004):

1. Power Distance: The degree to which members of a collective expect power to be distributed equally.
2. Uncertainty Avoidance: The extent to which a society, organization, or group relies on social norms, rules, and procedures to alleviate unpredictability of future events.
3. Humane Orientation: The degree to which a collective encourages and rewards individuals for being fair, altruistic, generous, caring, and kind to others.
4. Collectivism I: (Institutional) The degree to which organizational and societal institutional practices encourage and reward collective distribution of resources and collective action.
5. Collectivism II: (In-Group) The degree to which individuals express pride, loyalty, and cohesiveness in their organizations or families.
6. Assertiveness: The degree to which individuals are assertive, confrontational, and aggressive in their relationships with others.
7. Gender Egalitarianism: The degree to which a collective minimizes gender inequality.
8. Future Orientation: The extent to which individuals engage in future-oriented behaviors such as delaying gratification, planning, and investing in the future.
9. Performance Orientation: The degree to which a collective encourages and rewards group members for performance improvement and excellence.

The results of the study led the authors to include France in the group of "European Latin countries," including Israel, Italy, the French-speaking Swiss cantons, Spain and Portugal (House et al. 2004). The results observed in France compared to the average score of the study show (House et al. 2004):

- Less performance orientation
- More assertiveness
- Less future orientation
- Less human orientation
- Less collectivism (both individual and collective)
- Less gender egalitarianism
- More power distance

A review of the French literature was performed in June 2018 to better understand how this concept is used in the field of health and nursing. The French database *Banque de Données en Santé Publique* (BDSP®) was searched (Banque de Données en Santé Publique n.d.). In France, nursing education programs are necessary based on a national framework. National French competency frameworks and national curricula in nursing were also explored. Keywords and equations selected to perform this search are listed below:

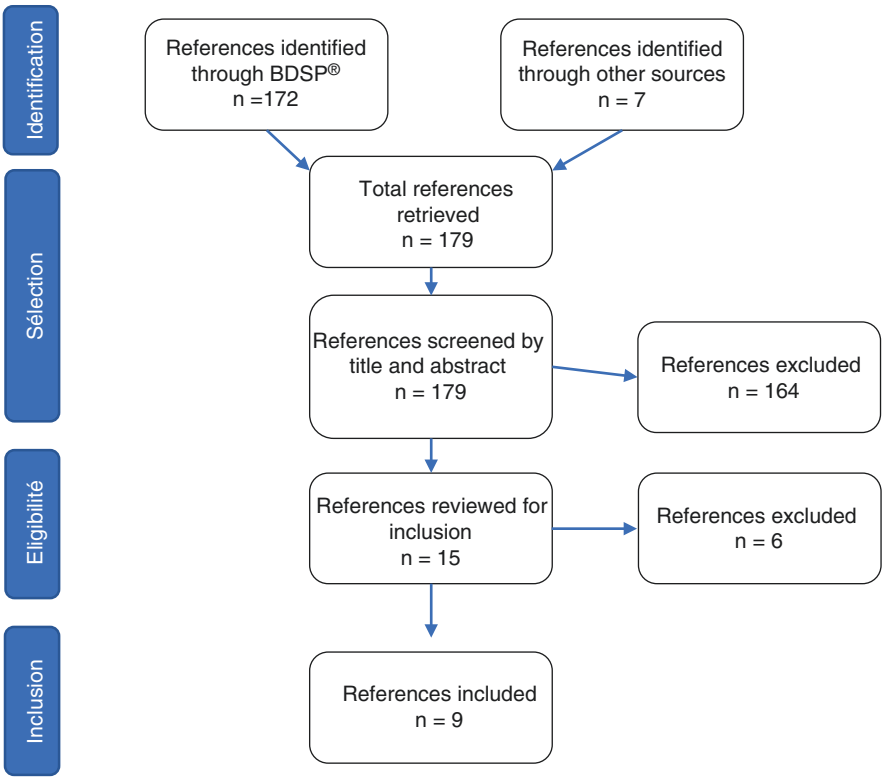
- Leadership infirmier
- Leadership and infirmier
- Leadership clinique
- Leadership and clinique and infirmier
- Leader et infirmier
- Infirmier et leader clinique
- Chef de file et infirmier

Inclusion and exclusion criteria were selected:

- Inclusion criteria
  - French context
  - Nursing profession
  - Publication written in French
- Exclusion criteria
  - French-speaking countries other than France
  - Healthcare professions other than nursing
  - Concept of management

A quantitative and qualitative analysis of references retrieved was performed.

The flowchart presented below shows the very few numbers of references available in France about this topic.



Finally, a comparison was made with the international literature found in Pubmed® database using the same keywords and equations. Keywords selected in French were translated in English using the "MeSH bilingue Inserm®"tool (Mesh Inserm n.d.).

	French database BDSP®	Pubmed®
Keywords and equations used	Leadership	Leadership
	Leadership infirmier	"Nursing leadership"
	Leadership and infirmier	Leadership and nursing
	Leadership clinique	"Clinical leadership"
	Leadership and clinique and infirmier	Clinical leadership and nursing
	Leader et infirmier	Leader and nurse
	Infirmier et leader clinique	"Clinical nurse leader"
	Chef de file et infirmier	Nurse leader

The results show the paucity of literature available in France compared to the international literature referenced in Pubmed® database.

18.5 National vs. International Literature Related to Nursing Leadership

BDSP® 30/6/18	Pubmed® 30/6/18
• Leadership: 1180 references	• Leadership: 37,351 references
• Leadership infirmier: 84 references	• "Nursing leadership": 14,951 references
• Leadership and infirmier: 84 references	• Leadership and nursing: 10,436 references
• Leadership clinique 29 references	• "Clinical leadership": 10,639 references
• Leadership and Clinique and infirmier: 9 references	• Clinical leadership and nursing: 3641 references
• Leader et infirmier: 46 references	• Leader and nurse: 1753 references
• Infirmier et leader clinique: 3 references	• "Clinical nurse leader": 501 references
• Chef de file et infirmier: 1 reference	• Nurse leader: 1434 references

The qualitative analysis reveals, on a linguistic perspective, that the concept of leadership has no equivalent in the French language. Only the term leader is translated by the concept "chef de file."

Leadership is rarely used in nursing terminology in France because this concept is traditionally considered as a synonym of management. As a result, the development of clinical leadership is hindered. Nurse managers and nurse executives often see leadership as their exclusive prerogative.

The nursing hierarchy in French hospital organization is composed of three layers:

- First-line management
- Middle management
- Strategic management

The functions of clinical leader and team leader do not exist in French healthcare organizations. The function of clinical nurse specialist is almost absent. A national program, initially launched in the 1950s, prepares first-line managers. Initially reserved for nurses, this program was opened in 1995 to other allied health professions.

Access to the position of first-line manager requires three conditions to be met:

- Possession of a minimum of 5 years of experience in nursing/allied health profession
- Successful completion of an entrance exam
- The validation of a 9-months dedicated education program implemented in an accredited institute of health management

However, nurses or allied health professionals who aspire to access to management functions may be assigned to this type of position on a transitional basis pending the success of the entry exam.

It should also be noted that the national education program for health managers has not been updated since 1995 (Duboys-Fresney and Perrin 1996) although many changes have taken place in the context of health and hospital management since the end of the 1990s. This program is on the reform agenda of the Ministry of Health, but it has been constantly postponed. As a result, the program is still implemented out of the realm of university despite the fact that the academization process has been underway in the nursing education since 2009. Managers, at the end of the program, do not necessarily obtain an academic master's degree. This is an important point to highlight because, historically, in the French hospital system, a person occupying a hierarchical position must have a higher level of qualification than that held by the people they supervise.

In the past, the first-line manager position included a mentoring role for the nurses of their team (Magnon 2001). The clinical expertise acquired by the manager before acceding to this position was used to advise teams facing complex situations or to provide support to nursing students and professionals during their orientation period. Since the end of the 1990s, the first-line manager function was reformed with a focus on management activities to sustain the implementation of hospital governance reforms (Divay 2017). In addition, many nurse executives have tended for many years to affect nurse managers in departments where they do not have previous clinical experience. As a result, managers are more and more distanced from clinical mentoring activities within the teams (Divay 2013). However, the vacuum created does not eliminate the needs of nurses. On the contrary, the complexity of patients' situations coupled with the ambitious objectives set by organizations increases needs and expectations of healthcare professionals in this area.

Clinical leaders are spontaneously emerging, but their leadership does not benefit from an appropriate theoretical framework and managerial support. The rapid turnover of nurses observed in teams leads more and more very young registered nurses to be identified as the leader within their team simply because they have more seniority in the unit. The spontaneous emergence of these clinical leaders is sometimes perceived as a threat to the authority of some nurse managers who consider leadership as a characteristic exclusively reserved for them. Moreover, the results of the analysis of the nursing programs (undergraduate and graduates) show that the term "leadership" is absent from many:

- Registered Nurses (2009)
- Nurse specialists
  - Childcare nurses (1983, modified in 1990)
  - Operating room nurses (2001 modified in 2015)
  - Nurse anesthetists (2012)
- Nurse managers (1995)

The term leadership is found, in association with the concept of management, in the nurse executive program implemented by the Ecole des Hautes Etudes en Santé Publique (2003 modified in 2017).

The APN's competency framework, published in July 2018, also includes the term "*clinical leadership*" (competence 5) (Ministère des solidarités et de la santé-Ministère de l'enseignement supérieur, de la recherche et de l'innovation 2018). Raising awareness among managers, educators, nurses, and nursing students in this field is made more difficult by the limited literature available in French on this subject and their competency in reading English nursing literature.

18.6 A Recent Development in the Context of Clinical Nursing Practice in France

July 2018 will remain in the history of nursing in France when advanced practice in nursing was officially introduced in the healthcare system to improve the access to medical care for the population (Ministère des solidarités et de la santé-Ministère de l'enseignement supérieur, de la recherche et de l'innovation 2018). This legislative development comes after nearly 20 years of discussions and negotiations. The Advanced practice nurse's profile introduced in France is mainly inspired by the clinical nurse specialist role as defined by the ICN APN NP Network and Hamric (Hamric et al. 2013; ICN, nd). It has the particularity of focusing exclusively on the follow-up of patients with stabilized chronic diseases, but French APNs do not have access to first-line consultations. This choice was made at the request of physicians practicing in a private practice basis to avoid any competition with APNs. Three areas of intervention have been identified (Ministère des solidarités et de la santé-Ministère de l'enseignement supérieur, de la recherche et de l'innovation 2018):

- Chronic diseases (with reference to a list of pathologies)
- Hemato-oncology and oncology
- Chronic kidney failure, dialysis, and kidney transplantation

A fourth domain, psychiatry-mental health, was added in August 2019.

The first students were admitted to the standard curriculum in 2018. The program, implemented by accredited universities, extends over four semesters. At the completion of the program, the university awards a state diploma to students enabling them to work as an APN in the field of intervention they have chosen. It also confers them the academic level of master's degree.

The effective deployment of the first graduates began in 2019 but will intensify from 2020. No quotas are currently in place to regulate the entry of students to the program. In addition, the French APN competency framework published in 2018 incorporates the notion of clinical leadership. The fifth competency stipulates: "*To set up and conduct actions to evaluate and improve professional practices by exercising clinical leadership*." It should be noted that for the first time the term, "*clinical leadership*" is used in nursing legislation in France, whereas this concept is widely explored in the international literature.

18.7 The Clinical Leadership Concept

De Souza and Klein defined clinical leadership as the "the process by which staff nurses exert significant influence over other individuals in the healthcare team, and although no formal authority has been vested in them facilitate individual and collective efforts to accomplish shared clinical objectives." The characteristics of this concept have been identified by Chávez and Yoder (2015) and by Stanley and Stanley (2018); they are derived from the those of the generic concept of leadership:

- Clinical leadership can be observed in healthcare providers whose activity is essentially clinical in nature.
- This type of leadership is not based on the existence of a subordinate relationship between leaders and followers, they maintain a functional relationship.
- Some healthcare professionals seem predisposed to developing this type of leadership.
- The clinical leader acts in accordance with his/her values and principles.
- Exemplarity must characterize his/her activities.
- The clinical leader influences the beliefs, attitudes, and motivation of members of a group to which he or she belongs.
- It inspires the people who follow it, and they often take it as a model.
- The relationship between the leader and his followers is necessarily based on trust and mutual respect.
- The clinical leader pays attention to followers, strives to empower them and, if necessary, provides them with support in the performance of their duties.

Thus, any nurse can become a leader within the team in which he or she practices. The modes of acquisition of the characteristics of a clinical leader were studied by Chávez and Yoder (2015). Three elements have been identified as essential to effective leadership:

- The leader possesses knowledge and strong clinical skills: these elements allow the leader to achieve positive care outcomes even in complex situations. These results give credibility to the leader within a team and thus support the modelling process.
- He or she must also implement effective communication within the team. This communication allows him to share his clinical conclusions with other professionals and to make his clinical reasoning explicit.
- Finally, he or she must be able to effectively coordinate care activities within a team without maintaining a subordinate relationship with the caregivers.

Once identified as a clinical leader, the nurse who wishes to maintain this clinical leadership within the team must strive to:

- Respect the standards of the team in which they work
- Encourage innovation and the updating of practices
- Offer appropriate support to team members in the change processes undertaken

At the end of this brief synthesis of the international literature on clinical leadership, it appears that any nurse can potentially become a leader within the team in which he or she practices. However, to develop, a synergy needs to be established between the manager and the clinical leader, the former promoting the emergence and affirmation of the latter.

18.8 Exercising Clinical Leadership: An Opportunity But Also a Challenge for Future APNs in the French Context

French APNs will have to mobilize the fifth competence of their competency framework within the team to which they will be assigned. In the current context and keeping in mind the way French culture approaches the notion of leadership, it seems necessary to carry out a SWOT analysis prior to the introduction of the role. The results of this analysis will guide the preparation of future as well as the deployment strategies developed by organizations that will introduce this new nursing function.

18.8.1 The Strengths

The first identifiable strength lies in the existence of legislation and regulations that give French APNs the mission to develop clinical leadership within teams. The second follows on from the previous one in that the national APN program will include dedicated educational activities aimed at developing specific clinical leadership skills in APN students. The clinical skills developed by APNs should help teams to achieve positive outcomes for patients and their families. This element will be an essential condition for APNs to acquire legitimacy and credibility with teams and therefore should facilitate the development of effective clinical leadership. In addition, the positioning of APNs at the interface of the nursing and medical groups can also facilitate the emergence of clinical leadership.

18.8.2 The Weaknesses

However, this analysis of the French context also reveals weaknesses. It is always difficult to familiarize students with a concept that is still poorly understood at the national level and, moreover, not to be able to benefit from a modelling process. A paucity of literature on the subject is available in the French language, as highlighted by the results of the bibliographic research conducted. This factor can hinder the development of leadership. Nurses and managers will therefore have to familiarize themselves with both the APN role and the notion of leadership and its components. It will probably be difficult at first for them to form realistic expectations in this domain.

The APN role is essentially clinically centered in response to the needs of the population and the inadequacies of medical care provision in France. The

non-clinical activities carried out by APNs with team members (for example, professional development and knowledge transfer) will probably remain rather marginal and will potentially be overshadowed by their clinical activities. This can be an asset as the clinical results they will obtain with patients will strengthen APN's credibility within the team but it is also a weakness, especially if the APN operates in a more isolated manner with limited contacts with staff nurses.

This phenomenon may be further increased for APNs working in private practice exercise keeping in mind the singular characteristics of the notion of team in the French community sector.

18.8.3 The Opportunities

Many opportunities to develop clinical leadership can be identified in the French health system and among healthcare teams. While ambitious goals and numerous directives are addressed to healthcare providers within organizations, many of them express the need for clinical mentoring, especially for the less experienced. The increased complexity of patients' situations combined with the current governance model, which emphasize versatility and mobility within huge departments grouping different specialities, further accentuate this need. However, this need is still insufficiently considered because of the refocusing of the first-line manager's activities on management activities, leading to a deterioration in the quality of life at work of healthcare professionals, an increase in the incidence of burn-out syndrome, and increased turnover within teams. The vicious circle produced is detrimental to patients, the structure, and healthcare professionals.

The objectives of performance, relevance, and effectiveness of care addressed to healthcare professionals in a context of frequent introduction of innovations and increasingly rapid obsolescence of knowledge require optimal knowledge transfer and the adoption of evidence-based practice. This process is still highly perfectible in France, as the Ministry of Health points out (Ministère des solidarités et de la Santé n.d.-b).

Attracting young people or people looking for a second career to the nursing profession is now a priority in France. Considering the growing healthcare needs of the population, attraction and retention of nurses need to be two main objectives in the future to reach the objective set by the ministry of health for the year 2040: increasing of 53% the number of nurses. Some domains of nursing practice need to develop their attractivity such as for example care of elderly people. The announced reform of the first-line manager preparation program is also an opportunity to broaden the vision of leadership in France and should encourage first-line managers to foster the development of clinical leader within the team they manage.

Finally, the Nursing Now® program, jointly run by the World Health Organization (WHO) and the International Council of Nurses (ICN), aims to achieve a broader inclusion of nurses in all health-related decision-making process and to provide them with the opportunity to develop the skills necessary to provide effective nursing leadership when they sit at a decision-making table. The "*Nightingale challenge*"

project also encourages employers to offer leadership training to a large number of nurses working in their organization, especially the youngest ones. A national Nursing Now® group (Nursing Now-France) was established at the initiative of the French National Association of Graduate and Student Nurses (ANFIIDE) during the first half of 2019. The increase in the activities of the Nursing Now® program will intensify in the second half of 2019 and peak in 2020 during the International Year of Nurse, as designated by WHO.

18.8.4 The Threats

In this analysis, threats that may hinder the development of effective clinical leadership by future APNs should not be minimized. The first potential threat will be the reaction of nurse mangers to the introduction of APNs. Most managers are poorly prepared for the introduction of this new function. Their lack of knowledge in this field only reinforces for some of them the feeling of being threatened in their territory, assimilating clinical leadership to managerial leadership. Moreover, the current healthcare system reform generates a lot of uncertainty for nurse managers, since changes are expected in their role and in the qualifications they will need to hold but the exact nature of these changes remains unknown. This situation generates anxiety especially because these decisions have been postponed many times.

This risk can be further increased by the academic level granted to APNs (they will be recognized at the master's level). Many nurse managers do not hold a master's degree or even a bachelors' degree for example, those who received their nursing diploma before the 2009 reform of preregistration national standard curriculum. In France, traditionally, the person who has the highest level of education must occupy the highest position in the hierarchy of the organization. This risk, combined with the hierarchical subordination relationship that will unite first-line managers and APNs, can constitute a major obstacle for APNs to the development of their clinical leadership in a health organization that has nursing management in place.

The relationship maintained by some nurses with the notion of clinical nursing expertise may also constitute another threat that should not be ignored. In France, nursing expertise is not recognized to the extent of the added value it produces, whether at the social, statutory, or financial level. Moreover, in France only three clinical nursing specialities are statutorily recognized. In the French system, career development often means that a nurse must leave the clinical activity to become a manager or an educator. In this context, the expertise possessed by some nurses is sometimes insufficiently recognized by other nurses.

This attitude is interpreted by some authors as the consequence of the existence of an oppressive mechanism within the professional group that prevents the nurse from placing value on one of her peers and makes it easier for her to turn to the oppressor for references and answers to questions. In this context, an APN who would take his/her leadership for granted upon her arrival in a team would also

pose a threat, especially if the APN has not previously worked as a nurse in that unit: credibility and legitimacy are essential to effective clinical leadership and their acquisition requires time that could not be reduced.

The last threat to consider is the relationship between the APN and clinical leaders who have spontaneously emerged within the teams and who do not benefit from statutory recognition, unlike APNs. The delay observed in introducing APN in France has led to much informal task shifting between health professionals, and managers have turned a blind eye to these situations in order to cope with the increased healthcare needs of the population. Now that advanced practice nursing is explicitly enshrined in legislation and regulations, the challenge is to encourage nurses to return to a strict adherence of their scope of practice and to forbid them from implementing medical interventions such as prescribing. However, nurses, who during many years have considered with a "certain freedom" the limits of their scope of practice in order to compensate for the inefficiencies of the health system, often express a lack of understanding regarding the expected benefits related to the recent introduction of APNs. Many staff nurses have difficulty understanding why it is now necessary to have a specific qualification to carry out certain interventions that they themselves sometimes performed on a daily basis, often more by imitation than by being able to specify the rationale behind their decisions and actions.

At the end of this SWOT analysis, three types of potential obstacles which could hinder APNs' clinical leadership in teams can be identified. Identifying potential obstacles is the first step which can lead to the implementation of preventive measures during the deployment phase of APNs in clinical environments:

- Obstacles related to the individual characteristics of the APN, particularly in relation to his/her mental image of leadership and his/her willingness to implement it is sometimes too early before having received enough clinical credibility by the healthcare team
- Obstacles intrinsic to the nursing group: the reaction of other nurses and nursing staff
- Obstacles extrinsic to the group: administrative and other health professions

18.9 Resources to Be Mobilized and a Strategy to Be Developed to Meet the Challenge

Given the number of scientific publications available on the subject, it is necessary that decisions about APN education, strategy of deployment in clinical settings, or promotion of clinical leadership among healthcare teams integrate the available evidence. As many authors point out, and regardless of the environment, establishing an effective communication campaign before introducing APN role should be the first priority in a deployment project (Boyko et al. 2016). Given the innovative nature of the role in France, the messages addressed to the various targets must be adapted, clearly and precisely.

This preparatory communication will enable the various actors to build appropriate representations of advanced practice nursing and its goals. Preparation will also enable the various actors to shape their expectations.

The development of the clinical leadership skills of future APNs during their studies is equally essential. The concept of leadership, and its application in clinical activities, must be clarified as well as the mechanisms for acquiring and maintaining it. Prior preparation of educators responsible for designing, implementing, and evaluating dedicated courses is necessary. The same applies to tutors who will supervise APN students in clinical placements.

Active teaching methods will be preferred in order to articulate teaching activities with clinical environments. In addition, since most students enter the program with a robust prior clinical experience, they will get benefits from the reflective practice sessions that punctuate the program to critically examine their clinical experience and thus develop the expected skills. The organization of joint projects and pedagogical activities with future first-line managers could also lead to a better knowledge of each other's roles and responsibilities and thus promote a more effective collaborative practice in the future.

Preparing the deployment of APNs within a health organization requires the clear definition of APN's hierarchical links within the structure in which she/he will practice. The traditional model consists of placing APNs under the supervision of the first-line manager responsible for the team in which APNs work. Alternative approaches can also be considered, such as a hierarchical link to middle management or directly to the nurse executive. It is the responsibility of the nurse executive to assess the degree of preparation of managers in this area and to make these decisions accordingly.

The deployment phase is also a crucial step (De Geest et al. 2008). It is essential to adopt a gradual increase in the number of responsibilities and objectives given to APNs following the orientation phase. The focus of the first months following the orientation phase must be on clinical activities to enable her/him to meet the characteristics required for effective clinical leadership. Only the clinical outcomes they will achieve with patients will provide legitimacy and credibility in the clinical field within the team.

The APN, in the collaborative approach maintained with the team, should aim to bring together the characteristics of a clinical leader. The APN should strive to empower nurses and create opportunities for knowledge transfer to another healthcare professional. The APN needs also to explicitly describe their clinical reasoning and decision-making processes, integrating evidence-based nursing into both the documentation in the patient's file and during clinical meetings. APNs will also have to coordinate patient care pathways.

This period also allows the new APN to develop a collaborative practice, certainly with physicians but also with other healthcare professionals.

First-line managers need to further develop their competency and skills in leadership. The Ministry of Health announced a profound reform of the preparation

program of first-line managers. This reform will provide the opportunity to develop this aspect of their role. Access to dedicated continuing education must be facilitated in order to raise awareness among managers already in practice. The aim is to change the representation managers have and thus to move from a feeling of perceived threat to the creation of a synergy between the managerial leadership implemented by managers and the clinical leadership developed by APNs, highlighting the outcomes expected from this collaboration (Brady Germain and Cummings 2010; Kotterman 2006; Kotter 2008).

Finally, these developments also provide an opportunity to make nursing students aware of the notion of leadership from the very beginning of their program (Daly et al. 2014; Ailey et al. 2015). A study currently underway, commissioned by the European Commission, aims to identify the elements that need to be updated in nursing competency frameworks within Europe and in nursing education to enable students to develop these competencies (Spark Legal Network n.d.). Let us hope that leadership is one of the elements that the participants in this study will want to see integrated into all nursing education programs in the European Union.

The impact of advanced practice must necessarily be assessed using appropriate indicators.

A first evaluation of the impact of the introduction of APNs in the French health system was requested by parliamentarians from the Ministry of Health before the end of 2021. The indicators that will be used and the methods selected are not yet known. It is therefore necessary for the nursing professional groups to ensure that the evaluation system to be adopted would be sufficiently comprehensive to include aspects related to the implementation of clinical leadership in any clinical environment.

Indicators published in international articles are available (Carrara et al. 2018), they will be adapted to the specificities of the French context and the profile of advanced practice nurses determined by national regulations.

For example, the specific instrument developed by Patrick (Patrick et al. 2011), the Clinical Leadership Survey (CLS), explores several areas related to clinical leadership from an individual perspective:

- Clinical expertise
- Interpersonal understanding
- Effective communication
- Collaboration

However, this instrument still needs to be adapted and validated in French before it can be used. But this individual assessment of clinical leadership skills must also include the consequences of effective leadership, particularly at the global level, on quality of work life, knowledge transfer, and the use of evidence-based practice.

18.10 Conclusion

This presentation of the French context illustrates the transition that is currently occurring in the French health system and in the nursing profession. Many challenges are associated with the development of effective nursing leadership in terms of efficiency and quality of care for the patient, but also in terms of team performance and, more broadly, the health system or the quality of life at work for nurses. These last two elements are of course essential to the attractiveness of the nursing profession and to the retention of its members.

Prospective studies estimate that the French healthcare system will need to attain a total number of 881,000 nurses in 2040 to adequately address the health needs of the population in the future (DREES 2018). It means that we need an increase of 53% in the number of practicing nurses. The coming months will be crucial both for the effective and efficient deployment of the first APNs and for the existential shift that managers will have to negotiate in a reconfigured organization. This period should be seen as an opportunity for both APNs and managers, even if the changes introduced are still a source of uncertainty and therefore anxiety.

APNs will also need to develop professional leadership at national, European, and international level, in particular through the ICN APN-NP network (ICN INP/APN Network n.d.). This should allow them the opportunity to make full use of the skills developed during their study for patients, healthcare professionals, and the system, but also to see the added value that they will certainly generate to receive appropriate social recognition.

The advanced practice nurse should not be seen as the solution to all the problems of a healthcare system in transition, but it will most certainly be a key factor in achieving the objectives set by the government in the "ma santé 2022" program (Daly et al. 2014). Promoting clinical nursing leadership in France requires the adoption of a global and synergistic approach that must mobilize all fields of nursing: practice, education, management but also research.

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Clinician Well-Being: Joy in Work

19

Seun Ross and Pamela Cipriano

Most healthcare workers desire to provide essential, high quality care to their patients and ensure their safety in keeping with the triple aim of health care to improve the health of populations and the patient experience and reduce the costs of care. To do so requires that care team members exhibit well-being.

19.1 Defining the Issue

Joy in practice or work is often described and measured as job satisfaction. However, joy is a broader concept described by Swensen and Shanafelt as "the aspirational state in which professionals are emotionally and behaviorally compassionately engaged in the care of patients and the mission of their organization" (Swensen and Shanafelt 2017). Joy has also been termed the antithesis of burnout and no single measure of satisfaction will reflect the complex set of factors affecting the work environment and clinician well-being. In the Healthy Work Place Trial (Linzer et al. 2017), 168 clinicians including 22 advanced practice providers in 34 clinics were followed prospectively to assess satisfaction and aspects of the workplace. The study found associations between the structural and cultural aspects of the work environment and joy in practice. Environments that were slower paced and less chaotic yielded higher satisfaction as did settings with clinician cohesion, good

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communication, trust, and shared values with leaders. More satisfied clinicians experienced less stress and burnout and were more likely to remain in the practice.

Han and colleagues (2018) reviewed close to three decades of literature for factors affecting APRN job satisfaction and intent to leave, primarily among nurse practitioners. Extrinsic factors such as salary, remuneration for duties beyond patient care, bonuses as monetary recognition, and equity in rewards were related to job satisfaction. Intrinsic factors such as autonomy, ability to influence, participation in decision-making, collegial relationships, administrative support, and time to participate in scholarly activities were also strong predictors of satisfaction. Not surprising was the finding that favorable practice environments were associated with more support for autonomy or independent practice, clear role definition and visibility, and better relationships with physicians and administrators. Burnout and intention to leave are lower for nurses working in environments with professional autonomy, ability to control their practice, and meaningful participation in decision-making (Copanitsanou et al. 2017).

19.1.1 Global Perspectives on APRN Practice and Role Satisfaction

The consistent forces driving the creation of APRN roles around the world are the need to improve access to primary care, increase quality, and deliver more cost-effective care. More than 50 countries and territories have some type of APRN role across the African, Asian, Australian, European, Central American, North American, South American, and Pacific Island regions. What remains problematic are barriers to implementation which must be addressed so that there is standardization of titles and title protection, effective regulation processes, role clarity, identity and definitions, consistent educational requirements, and appropriate reimbursement, salary and benefits (Schober 2018; Steinke et al. 2018; Fougère et al. 2016). Full acceptance from various stakeholders, primarily physicians and administrators is also a barrier to be addressed. No matter the country, these issues are restraining forces and are consistent drivers of dissatisfaction.

The 2017 OECD report, *Nurses in advanced roles in primary care: Policy levers for implementation* (Maier et al. 2017), reinforces the need to accelerate the deployment of APRNs in order to address primary care needs around the world. The report stresses the need to standardize titles that address minimum practice levels and commonly agreed upon definitions, which would have the positive effect of increasing recognition of the roles and individuals.

Similar to general duty nurses, the work environment is key to joy in work for APRNs. However, APRNs cite characteristics of their roles as important to their satisfaction including professional autonomy, visibility of their role, respect for their competence and opinion, relationships and collaboration with physicians, teamwork and intraprofessional relationships, participation in research and scholarly activities, and support from the healthcare community and policy makers. The degree to which countries deliver on these conditions is highly variable as well (Steinke et al. 2018; Poghosyan et al. 2017; O'Keeffe et al. 2015). A sampling of reports from a number of countries illustrates the work still to be done to improve the implementation and fulfillment for APRNs:

- Australia: Primary care APRNs report satisfaction levels of 70–80% but cite detractors such as time constraints, lack of respect and recognition, role limitations, and concerns about funding models (Halcombe and Ashley 2016).
- New Zealand: While the NP has a clearly defined role and scope of practice in legislation, the CNS has no formal or legal definition. There is role overlap among NP, CNS, and clinical nurse consultant roles in both Australia and New Zealand (Carryer et al. 2018; Gardner et al. 2015).
- Canada: Titles are difficult to understand, roles are not well understood, and there is role overlap between nurse practitioners (primary health care and acute care) and the CNS role. Some CNSs report an overreliance on them to provide a high degree of consultation focused on addressing complex health need as well as to improve quality outside in their organizations (Kilpatrick et al. 2016; Bryant-Lukosius et al. 2010; Donald et al. 2010).
- Ireland: APRNs do not feel empowered. They would like greater involvement in research, earning opportunities for services provided outside of normal working hours, greater administrative support, and more say in determining bonuses and compensation related to productivity (O'Keeffe et al. 2015).
- England: An increase in administrative tasks is detracting from the ability to deliver care. A more permissive approach to regulation is not uniformly embraced and APNs voice concern over title protection (Steinke et al. 2018; Kleinpell et al. 2014; King et al. 2017).
- Finland: The country is seeking standardized titles and job descriptions at the national level and is exploring additional regulation for both NPs and CNSs (Finnish Nurses Association 2016).
- Scotland: Several specialty roles for advanced nurse practitioners have been developed but there is need to clarify the role of the CNS (Cooper and Docherty 2018).
- Israel: Nurse specialists have a very limited scope of practice, thus underutilizing education and skills (Kleinpell et al. 2014).
- Portugal: Stakeholders have not agreed on the development and implementation of advanced roles for the country. Nurses are seeking a policy discussion with country leaders that will establish and support APRNs (Buchan et al. 2013).
- China: As more graduate programs develop, work continues to address the need for standardization and certification of programs (Kleinpell et al. 2014; Hill et al. 2017). There is great interest in developing APRN roles based on those well developed in the USA, Canada, and Australia. Hong Kong has already adopted the nurse specialist title but it is not regulated or credentialed; nurse practitioner roles in primary care are being developed to expand the scope of practice of the APN.
- Switzerland: Master's level education is being proposed for implementation in 2020 for clinical experts. Professional efforts are focused on implementing regulation and credentialing for CNS and NP roles in order to distinguish the roles (Zumstein-Shaha 2018).
- United States: There is variation among the 50 states and territories regarding scope of practice, level of autonomy represented in requirements for supervision or collaborative practice agreements, degree of prescriptive authority, and opposition from physician groups.

Addressing the intrinsic factors related to scope of practice, role clarity, regulation, autonomy, relationships, role recognition, and respect is essential to ensuring joy in practice and clinician well-being. Improving the extrinsic factors associated with the work environment and conditions of reimbursement, compensation, and support systems will also contribute to much greater satisfaction in carrying out the role.

19.1.2 Addressing Lack of Joy and Well-Being

Burnout in healthcare workers in clinical or public health terms is a worldwide epidemic (Perlo et al. 2017). Burnout syndrome is associated with emotionally intense work demands, and results in exhaustion, cynicism, and decreased work effectiveness (Shanafelt et al. 2017a). Less is known about the level of burnout specifically in advanced practice nurses; however, drivers of burnout for both general nurses and physicians are commonly cited as contributing to job satisfaction or dissatisfaction among APRNs. Burnout syndrome among healthcare providers has been linked to poorer quality of care outcomes including self-reported medical errors, increased patient mortality, clinician depression, and substantial financial costs to the healthcare system (Moss et al. 2016; Shanafelt et al. 2016, 2017b; Wallace et al. 2009; Aiken et al. 2008). For these reasons, there is strong desire to return joy to work to safeguard quality of care, ensure care for caregivers, and retain them in the workforce.

Among healthcare providers in the United States, the prevalence of burnout syndrome appears to have been increasing over the past decade, with one-third of nurses and over half of physicians reporting symptoms of burnout (Shanafelt et al. 2015a; Dyrbye et al. 2017; McHugh et al. 2011). The alarming rise in the rate of physician burnout and suicides (Shanafelt et al. 2015a) was the catalyst for the National Academy of Medicine (NAM) to form the Action Collaborative on Clinician Well-Being and Resilience in 2017 led by the American Association of Medical Colleges and the Accreditation Council for Graduate Medical Education (Bryant-Lukosius et al. 2010; National Academy of Medicine 2017). The Collaborative includes a network of over 60 organizations committed to reducing clinician burnout. As an interprofessional group, nursing is well represented by the American Nurses Association (Steering Committee member), the American Association of Critical Care nurses (Steering Committee member), the American Association of Colleges of Nursing, and the National League for Nursing.

The Collaborative's three goals are to:

1. "Raise the visibility of clinician anxiety, burnout, depression, stress, and suicide
2. Improve baseline understanding of challenges to clinician well-being.
3. Advance evidence-based, multidisciplinary solutions to improve patient care by caring for the caregiver" (National Academy of Medicine 2017).

In its first 2 years, the Collaborative has created a knowledge hub with extensive resources, created a conceptual model to understand and study clinician well-being and resilience, and initiated workgroups to propose solutions to alleviate the external factors creating clinician stress and burnout, and promote strategies for improved workflow and workload among other activities. Work continues to focus on ensuring a healthy clinical learning and work environment as well as cultivating top leadership support to reimagine and construct the future state for all clinicians.

One of the more serious drivers of burnout, particularly in nurses, is moral distress (Epstein and Delgado 2010). When nurses or other clinicians experience situations where incompatibility exists between what is best for a patient and what is perceived as best for the organization or others, a professional, societal, and organizational conflict arises. Clinicians know the right course of action but feel constrained from carrying out those actions even when there is ethical justification.

19.2 Foundations for Clinician Well-Being and Joy in Work

Provision 5 of the *ANA Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association 2015), "Promotion of Personal Health, Safety and Well-Being" addresses the duty of a nurse to care for self and states, "the nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth." Nurses must own their individual health in order to foster a healthy personal and professional balance. The responsibility for self-care may also be referred to as self-stewardship. The broad notion of self-stewardship conveys regard and preservation for one's well-being while acknowledging one's needs and limitations while caring for others (American Nurses Association 2019; Holtz et al. 2017). The International Council of Nurses' Code of Ethics also advocates for promoting healthy life styles as well as the personal health of nurses to maintain competent practice (International Council of Nurses 2012).

19.3 The Importance of Personal Well-Being

Motivated to "do no harm," clinicians frequently place the welfare of their patients first, often sacrificing sleep, meals, and personal and family time to be available to their patients. While noble, the financial pressures to reduce rising healthcare costs and the ever-growing requirements for documentation in the electronic health record have increased pressure for clinicians to improve productivity while simultaneously requiring them to use technologies that can reduce productivity and contribute significantly to clinicians' burdens and burnout. Advanced practice nurses experience conditions similar to those of physicians but they also share many of the factors affecting the work life of clinical staff nurses. Workload issues such as clerical work and documentation burden, volume of patients, level of autonomy,

leadership behaviors, pay, and emotional labor and moral distress all impact clinician well-being and the potential for burnout (Dyrbye et al. 2017). Bodenheimer and Sinsky (2014) posit the need to expand the triple aim to include a fourth aim to improve the work life of clinicians and staff. Without care team well-being, burnout, and dissatisfaction among the workforce threatens patient centeredness and ignites a domino effect of lower patient satisfaction and reductions in quality outcomes.

The rising tide of chronic or noncommunicable diseases has significantly altered how APRNs practice. Chronic diseases account for almost 70% of the deaths annually worldwide (World Health Organization 2011). The overwhelming prevalence of chronic diseases places burdens on primary care providers striving to prevent as well as manage conditions that lead to premature death (Johnson et al. 2010). APRNs are targeted as the answer to the shortage of primary care providers and are leading the way by demonstrating positive results in managing complex patients with chronic conditions. However, many APRNs receive lower reimbursement and ultimately less compensation than their physician counterparts, which compounds the stresses of managing a private practice. Few APRNs own their practices, which likely accounts for some of the difference in lower compensation. In countries with incentive payments for quality, depending on the individual practice APRNs may not be included in the sharing of incentive payments.

19.3.1 Stress as a Major Threat to Joy

Nurses often experience significant stress when there is misalignment of personal and private values with their practice. The lack of value congruence drives emotional exhaustion and depersonalization and can have a significant effect leading to moral distress and burnout (Rushton et al. 2015; Shao et al. 2018). Daily ethical challenges such as futile or inappropriate care take a high emotional toll and can also lead to unrelieved suffering as well as create the sense of excessive workload. Lack of adequate preparation to address the emotional and spiritual needs of patients and their families, weak or no support systems, and ambiguity about a plan of care also contribute to moral distress. Together these conditions fuel a constellation of factors associated with burnout such as depression, anxiety, diminished physical and mental health, intent to leave, depersonalization, disengagement, and emotional exhaustion.

19.3.2 Resilience: Antidote for Stress

The American Psychological Association describes resilience as, “the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress—such as family and relationship problems, serious health problems or workplace and financial stressors. It means ‘bouncing back’ from difficult experiences” (American Psychological Association 2014). Nurses and other

professionals possess some innate ability and learned capacities to cope with the ever-present high stress situations of health care. Strengthening one's coping ability and building new skills to mitigate distress are essential steps toward building resilience to combat the effects of stress. Also recognizing that moral distress is pervasive in nursing practice necessitates a discussion of building moral resilience and other potential strategies that can be used to foster this quality within individual healthcare professionals.

Building capacity for moral resilience begins with having a solid foundation of knowledge and understanding of ethics and ethical practice. Nurses must be able to identify the ethical issues that are inherent in their complex practice environments and identify the appropriate actions that should be taken to address each situation. Additionally, developing ethical competence requires developing individual coping skills and problem-solving abilities that will also act as protective factors (American Nurses Association 2019).

In general, methods to develop resilience vary greatly among settings and individuals. Nurses use different coping strategies such as seeking support from co-workers and creating a stronger sense of team, maintaining positive work-life balance, and seeking greater satisfaction by caring for patients where they can provide more holistic care. Organizations may use multiple approaches to reducing stress and providing skill building for resilience such as debriefing sessions following a traumatic event, having a resilience mentor, and offering cognitive behavioral therapies (Turner 2014). Implementing a SMART (Stress Management and Resilience Training) program can also reduce anxiety, stress, and burnout and create benefits in mindfulness and resilience (Magtibay et al. 2017).

Maintaining value congruence when faced with a challenging situation is a characteristic of moral resilience and integrity. Being able to recognize and evaluate a challenge or resistance the moment it occurs can be difficult. The ability to adapt one's response to a challenge without being overwhelmed characterizes a capacity for self-regulation, which relies on using mindfulness, a reliable technique for reducing stress (Holtz et al. 2017). Dr. Jon Kabat-Zinn's popular operational definition of mindfulness is "the awareness that arises from paying attention, on purpose, in the present moment, and non-judgmentally" (Purser 2015). He is credited with developing mindfulness stress reduction, which was originally focused on alleviating stress related to pain and illness, and has been found to reduce emotional exhaustion, enhance relaxation, and reduce burnout in clinicians (Cohen-Katz et al. 2005; Mackenzie et al. 2016; Pipe et al. 2009). Mindfulness helps modulate the intensity of an emotional response to a stress stimulus from adversity (Rushton 2016). Developing mindfulness skills for a more positive mental and emotional approach to challenges enables individuals to increase their personal and organizational resilience (Foureur et al. 2013).

Focused on helping nurses be healthy, the American Nurses Association (ANA) began offering an online personal health risk appraisal in 2013. Results from more than 10,000 nurses revealed that nurses were less healthy overall than the general population. More alarming was the finding that nurses reported rates of work-related

stress as twice that of the general public—82–41% and 1 in 4 has been assaulted at work. These alarming conditions led to the launch of ANA's HealthyNurse, HealthyNation™ Grand Challenge in 2017 (American Nurses Association 2017). The aim is to improve the health of US nurses in five domains to ultimately improve the health of the nation: physical activity, rest, nutrition, safety, and quality of life. All of these contribute to well-being with the domain of quality of life focused on factors that will reduce stress and increase one's self-care.

19.4 Leadership Imperative

Major accountability for cultivating joy in work and clinician well-being accrues to the leaders of the healthcare organization, no matter how big or small. Leaders have a vested interest as well as responsibility to provide a healthy clinical environment that cultivates engagement and satisfaction and mitigates the drivers of burnout. Clinicians also share the responsibility for the practice environment but should never shoulder it alone. When organizations assume the individual alone is accountable to be resilient, find joy in work and prevent burnout, this strategy often yields a narrow list of solutions that are unlikely to result in meaningful progress. For example, suggesting that individuals pursue stress management workshops and individual training in mindfulness or resilience in the absence of a commitment to address systemic issues that impact joy at work. Leaders must assess and address the organizational factors that are the primary drivers of clinician burnout to alleviate the problems. Without leader investment and a palpable healthy work environment, we are likely to see a greater intent to leave and turnover of clinicians either in that job, in the profession, or both.

The direct effects of leadership on clinician satisfaction and burnout are just being recognized, despite the fact that we have known for some time leadership's impact on other organizational success measures (Shanafelt et al. 2015b). Promoting an environment that supports joy and well-being for all care team members requires effective leadership to promote individual and organizational health.

Boards of trustees charged with responsibility for an organization to meet its mission need to understand the deleterious effects of clinician burnout and treat it as a threat to safe patient care. Ensuring that the organization is committed to addressing any organizational factors that diminish joy in work is a strategic concern. Attention to leadership development of front-line leaders and managers, together with nurses, physicians, and other professionals is essential. The general factors driving burnout affecting APRNs such as poorly functioning teams, efficiency of the practice environment, incongruent values, workflow, work hours, care team consistency, poor or ineffective leadership, and availability of resources align most closely with those of physicians. More specifically, APRNs experience additional challenges related to high variability in their range of responsibilities, level of autonomy and flexibility.

19.5 Taking Action to Promote Clinician Well-Being and Joy in Work

Evidence continues to build that clinician well-being is critical to the health of both patients and healthcare systems. Without well-being, burnout can degrade not only the quality of patient care but also the economic performance of a practice or organization. Burnout leads to lower staff engagement, which adversely affects patient satisfaction and engagement, and erodes productivity. Burnout also limits providers' empathy, which is necessary for person-centered care (Perlo et al. 2017). Focusing on joy—not solely burnout, engagement, or turnover—provides an asset-based approach to solve intractable problems in achieving health and health care. Joy is not just the absence of burnout, but it encompasses a system of healthy thriving individuals and organizations.

Actions to ensure or restore joy in practice occur at the organizational and individual levels. Swensen and Shanafelt (2017) propose an organizational framework with six evidence-based actions to mitigate drivers of burnout, strengthen individual resilience, and bring joy back to practice. Their action steps are briefly described in Table 19.1.

Table 19.1 Framework to reduce professional burnout and bring back joy in practice (adapted, Swensen and Shanafelt (2017); Shanafelt and Noseworthy (2017))

1. Design organizational systems to address human needs
(a) Policies, processes, systems, and culture must support a sense of meaning, purpose, and autonomy for clinicians
(b) Involvement in selection, assessment, and development of leaders
(c) Meaningful involvement in decisions
(d) Appropriate workloads and ability to control work processes
2. Develop leaders with participative management competency
(a) Leadership style must be inclusive to engage staff in analyzing and solving problems
(b) Create trusted partner relationships and measure leader behaviors and performance
3. Build social community
(a) High functioning teams exhibit collegial respectful relationships
(b) Foster sense of community through team-based decision-making, shared meals, spaces, and social gatherings
4. Remove sources of frustration and inefficiency
(a) Uncover the sources diminishing joy through discussion and active listening
(b) Implement quality improvement to remove inefficiencies
(c) Return control of the work environment to clinicians
(d) Eliminate unnecessary tasks
5. Reduce preventable patient harm and support second victims
(a) Ensure a fair and just culture
(b) Assemble interdisciplinary teams to address any root causes of harm
(c) Support staff involved in a traumatic event
6. Bolster individual wellness
(a) Implement programs for organizational and individual resilience
(b) Provide access to wellness programs and encourage participation

The Institute for Healthcare Improvement also offers a Framework for Improving Joy in Work, which includes four steps for leaders and nine essential components of a system to support a joyful and engaged workforce (Perlo et al. 2017). The framework directs leaders to learn what is important to their employees; identify unique barriers to joy within their organizations; adopt a systems approach to cultivating joy as a shared responsibility; and use improvement science to test approaches that will improve joy. The desired result is that leaders and individuals at all levels share responsibility to nurture joy in work so that all healthcare workers find meaning and purpose in what they do. Table 19.2 describes the nine components of the framework.

Both of these frameworks offer interventions that blend common elements including systems that provide clinician autonomy, leaders who promote inclusion and engender trust, a focus on safety, quality improvement and well-being, a sense of community and teamwork, and actions to remove barriers preventing joy in work with a commitment to measure progress regularly. The key is applying both organizational and individual level strategies to reduce burnout and promote engagement.

Table 19.2 Critical components of the IHI framework for improving joy in work (Perlo et al. 2017)

Physical and psychological safety	• Work environment is free from physical harm • A just culture supports staff in adverse events and encourages them to admit mistakes • Respectful interactions • Free to ask questions, ask for feedback, propose ideas • Equity across team members • Feel secure
Meaning and purpose	• People find meaning in their work • Feel connected to greater service mission
Choice and autonomy	• Support for flexibility to make choices and determine how one carries out work • Have a voice in decisions
Recognition and rewards	• Meaningful recognition • Celebrate outcomes and accomplishments of individuals and teams
Participative management	• Leaders listen, understand, and seek team member input and involvement • Clear communication for consensus building and decision-making
Camaraderie and teamwork	• Teams develop social cohesion and trusting relationships • Team members express appreciation for one another's contributions
Daily improvement	• Improvement science is the approach for systems and process improvements • Daily learning occurs from evaluating successes and defects
Wellness and resilience	• Culture values health and wellness of all individuals • Helps individuals cultivate resilience • Appreciation for work-life balance and whole person • Encourages care for self
Real-time measurement	• System performance is measured regularly • Data are used for ongoing improvement

Organizations should also measure clinician well-being as a routine institutional performance metric and some have suggested that wellness be a routine quality indicator given the relationship of clinician well-being and patient outcomes (Dyrbye et al. 2017; Spinelli 2013). All organizations should measure and address the factors that they believe are crucial to achieving their mission. A number of standardized instruments are available to measure a variety of aspects of clinician well-being, burnout, engagement, satisfaction, stress, emotional health, and various dimensions of quality of life. Using standardized instruments allows for national benchmarking, which can help provide a context for interpreting results. Organizations should assess their selected dimensions at regular intervals. Results should be reported to governing board members along with other key performance metrics including any correlations that can be made between well-being and resilience or low burnout and measures of quality, safety, patient engagement, turnover, and finances.

19.5.1 Organizational Support for Clinicians

APRNs have a responsibility to safeguard their practice by taking personal responsibility to be healthy physically, mentally, emotionally, and spiritually. Being assertive to address the work environment, pursue work-life integration, and develop productive relationships with other team members are not just aspirations, they are requisite to fostering joy in work and preventing burnout. Organizations must also support clinicians by providing environments that offer physical and psychological safety, work that has meaning and purpose and an acceptable level of professional autonomy. Clinicians must feel safe and free from bodily harm. They also need a safe psychological environment that encourages open two-way communication and a just culture that provides support during and after an adverse event. Since APRNs may be solo practitioners or small in number within a practice setting, they may need to seek others across an institution or in the broader professional community to have a reference group for support (Watts 2019).

Clinicians want their work to be meaningful. Affirmation through formal recognition and celebration provides validation of one's work and worth. It also connects the individual to the greater mission of the whole organization or practice. One of the corrosive forces of well-being is loss of autonomy or control. Professionals want to be able to direct the care of their patients without interference or retribution from others who might prioritize productivity, efficiency, and financial gains over patient needs. They need to exert control over the scope and span of practice in order to serve their patient population. APRN clinicians and their employers or partners need to work together to establish a positive healthy and ethical work environment. The environment must support autonomy, flexibility, and regard for the voice of the clinician in establishing and controlling practice. When roles are similar to physician practice such as a primary care nurse practitioner, APRNs also expect to be afforded the same level of support staff in their practice settings.

With a significant emphasis on patient safety, organizations are encouraged to assess the work environment and climate. A large cross-sectional study of over

10,000 staff in a large academic health system showed the benefits of examining the safety culture and its relationship with work-life integration as an influencer of burnout. Results using the instrument, SCORE (Safety, Communication, Operational Reliability, and Engagement), showed that work-life climate had the strongest association with both burnout climate and personal burnout. Only about 45% of physicians rated their work-life integration as good, whereas 60% of APRNs and 65% of staff nurses reported good work-life integration. Addressing conditions that can improve work-life integration is an effective means to reduce emotional exhaustion, reduce errors, and improve quality and safety (Schwartz et al. 2019).

19.6 Case Example

Lorraine Flournoy (fictitious name) is a clinician, wife, and mother of two children. For 7 years she worked as a labor and delivery nurse in an inner-city university hospital. As a registered nurse she saw how the disparities and inequities in care affected her patients and eventually their children. Those experiences lead her to pursue and obtain an MSN-FNP degree. After passing her certification exam, she was excited to be hired to work in a clinic that provided reproductive care.

During her 2-week orientation learning the policies, procedures, and the culture of the organization, Lorraine was told she would have to meet daily patient quotas and a standard throughput time. She was expected to see 30 patients a day. The time spent with each patient would be a minimum 15 min visit with a total for all care required from her and any other team members, including procedures, to be done in under 60 min.

Thrilled to start managing patients by herself, her first month alone was difficult. Lorraine wondered how it was possible to develop a rapport with a patient, conduct an assessment, insert an implant, and complete electronic documentation within a 59-min timeframe. Lorraine quickly felt she was being asked to do the impossible.

19.6.1 Are Lorraine's Feelings a Sign of Moral Distress or Burnout? What Steps, If Any, Can Lorraine Take to Alleviate or Stop the Progression of These Feelings?

As time passed, Lorraine began to feel inadequate because she was calling the senior NP for 1 out of every 2 patients and her average throughput time was 90 min. To make matters worse, Lorraine received a special visit from the medical director who asked if this role was the right fit and if she could handle the pace of the environment. Feelings of dread and despair began to overwhelm her. She started to feel anxious whenever she viewed her daily patient schedule in the mornings. Following the visit from the medical director she was given a "grace period" to meet throughput expectations; this concession created more internal self-doubt about her abilities. She would have to drastically reduce her times in

short order and she already felt as if she were rushing. She began to feel her clinical education or her orientation was not structured for her success, because her training was so different from real life. Internally she began to resent the workplace and question her skill level as a NP.

19.6.2 What Changes Can be Made to Assist Lorraine in This Role/Environment? Are There Any Changes the Organization Can Make to Assist Lorraine?

Every night Lorraine drove home thinking how and where she could make any changes. She began to feel she made a mistake in becoming an APRN and thinking of ways to improve the situation was only making her more depressed, furthering her feelings of resentment and self-loathing. The joy and love she once had for nursing were beginning to disappear. She thought a solution would be for the practice to hire another NP, but she knew practice leaders would deny the request claiming it exceeded the available budget. The clinic staff already included herself and three other medical assistants.

Lorraine then decided to call her NP network colleagues. While in school, she bonded with a few friends that continued after graduation. She often reached out to them with clinical questions, so she decided to engage them at this crossroads in her career. Each of them expressed various times where they had felt the same feelings and offered helpful suggestions. One colleague recommended she shadow another NP who worked for the same organization and who was meeting expectations. Lorraine met with the Medical Director and asked to shadow a senior level NP. The request was approved and Lorraine felt relieved, supported and heard which fostered a sense of trust and appreciation in her organization.

The camaraderie from her senior NP colleague helped put her at ease and she learned a few tricks of the trade. Once she returned to her clinic, Lorraine was able to reduce her throughput time to 52 min. The suggestion to find a mentor to continue developing her skills as a clinician aided in increasing her competence, solidifying her confidence, and meeting throughput expectations, which put her on the path of reclaiming the joy she once had when she became an NP.

19.7 Conclusion

The value of clinician well-being has been established. The necessity to enhance the work environment and support clinicians so they can deliver high quality safe patient care and experience joy is indisputable. Taking steps to diminish or eliminate drivers of burnout are the next steps for everyone in health care locally and at the system level. Many of the challenges and solutions are local (Sinsky et al. 2013). The most promising targets for action improving the environment for APRN practice are:

1. Reengineer systems to create a work environment with well-being as a goal.
   (a) Redesign workflows to remove inefficiencies including unnecessary documentation and clerical work by optimizing use of technologies.
   (b) Cultivate team-based care.
   (c) Improve team communication.
   (d) Utilize patient co-management and share care among team members (Sinsky et al. 2013; Norful et al. 2018).
2. Promote and engage in self-care strategies that promote work-life integration and stress relief.
   (a) Provide professional and self-help resources to enhance resilience.
   (b) Provide educational opportunities to learn:
      - Mindfulness and Mindfulness Stress Reduction.
      - Conflict Resolution.
3. Measure well-being routinely and review with same level of importance as financial, quality, and patient satisfaction indicators.
4. Construct appropriate rewards and incentives.

Creating and maintaining healthy and ethical work environments promote clinician well-being. Together with individual and organizational strategies to prevent burnout and help cultivate resilience, clinicians and their organizations can safeguard patient care and foster clinician joy.

Country level efforts to develop APRN roles that are clearly understood with title protection, a scope of practice that provides for autonomy, and appropriate regulation are welcomed. Professional nursing associations, healthcare organizations, and governments are working toward cultivating greater role recognition and respect as well as support from physicians and other clinical and administrative colleagues. Professional associations and governments will continue to work together to remove barriers to implementation, and bring clarity through approaches such as standardized titles, education, and approaches to regulation. Together these efforts will be essential to establishing practice conditions that create satisfying roles and environments.

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Part VI

Leadership Development

This section focuses on the various aspects of leadership development as well as on characteristics that are most common in leaders such as coaching and mentoring of younger nurses, consensus building, entrepreneurship, and advocacy.

The first chapter focuses on coaching and mentoring future leaders. Building future Advanced Practice Nurse (APN) leaders ensures that the extensive work to enable APN practice will continue. The importance of coaching and mentoring is described including the rationale for the integration of these skills into the core work of current leaders. Included are suggestions on how to be a coach/mentor with an exploration of how each is different and the principles of applying each skill.

The next chapter emphasizes leadership by consensus building through working with stakeholders within and outside of nursing. This chapter focuses on why being a coach/mentor leader is important, what coaching/mentoring by APN leaders looks like, and how to build a culture that supports coaching and mentoring. Succession planning is also a major outcome of coaching and mentoring as we begin to consider future APN leadership.

The chapter on collaborative leadership provides a powerful example of how one leader used collaboration as a method of introducing a new role in Latin America. It provides an example of how collaboration can be used as a leadership strategy bringing all stakeholders together to make change.

The chapter on entrepreneurship focuses on the leadership ability to build new businesses using visionary thinking, financial management, and business acumen. This chapter takes a fresh look at innovation and leadership and uses poignant examples and case studies to make the point.

The chapter on advocacy focuses on several principles of advocacy for policy change by advanced practice nurses in the United States and globally. As an essential component in advanced practice nursing education, the role of advocacy for consumers differs from that of advocacy for the profession. Using advocacy strategies from the American Association of Retired Persons and the American Association of Nurse Practitioners, advanced practice nurses from states with restricted laws were equipped with winning strategies to increase legislative efforts in their states.

Finally, Partners in Health, a Boston-based NGO recognized as a leader in global health delivery, provides a retrospective case study documenting the organization's roots and the evolution of nursing within its history. The case study highlights two Partners in Health country sites in Haiti and Liberia, which not only showcase nursing leadership as a mechanism to improve patient care but also demonstrate the realities of developing and improving the nursing profession in challenging conditions.

Building a Legacy of Leadership Through Coaching and Mentorship

20

Aimee Holland, Rachel Sposito, and Jean Johnson

Advanced practice nurse leaders create a legacy by ensuring a future generation of leaders through coaching and mentoring. A coach/mentor leader helps less experienced nurses build their leadership capacity and ensures the continuation of work critical to the global future of millions of people who depend on the effectiveness of advanced practice nursing. Succession planning is part of building a legacy for the smooth transition of new leadership (Ramseur et al. 2018; Graystone 2019). For APNs to continue to build on the successes of the past, ongoing leadership is needed to provide access to clinical care, improve quality and safety, address constraints to practice, and work to make health care affordable. This chapter will focus on why being a coach/mentor leader is important, what coaching/mentoring by APN leaders looks like, and how to build a culture that supports coaching and mentoring.

20.1 The Importance of Building Leadership Capacity

Every leader thinks about their legacy—what will continue after they leave and what contribution is worthy of being remembered. We believe that the most important legacy of a leader is having developed future leaders. Helping others build

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leadership capacity is how important work carries forward. The legacy of a leader is not to have someone continue their exact work, but to have future leaders create their own vision, mission, and goals. A coach/mentor builds future leaders who are not afraid to embrace change, to think creatively, and take risks to move a vision forward. The enduring legacy is when a leader deeply enriches others by investing in their development. People choose to work with leaders who care about them, are trustworthy, and provide stability and hope (Rath and Conchie 2008).

No matter what the focus of the APN leader's work, creating a vision for the future, building trust, and demonstrating caring and compassion is how dynamic leaders thrive. Trust takes time to establish and can easily be broken. Great leaders know how important trusting relationships are to success. Followers want to know that their work has a purpose, makes a positive difference, and is valued, and also that they—as individuals—are valued. Leaders can communicate caring in various ways. Something as simple as acknowledging an employee's birthday or anniversary with the company can mean a lot as does supporting a request to attend a child's school performance during work hours. Every person need to feel valued especially in the workplace where we spend so much of our time.

Building leadership capacity is largely about reaching team members at an emotional level to empower, educate, and be a role model. This creates a consistent, humanistic and a productive cycle of next generation leaders. Maya Angelou has offered, "people will forget what you said, people will forget what you did, but people will remember how you made them feel " (Kelly 2003, p.263).

While leaders need to have technical skills in communications, budgeting, resource management, strategic planning, and others, they also need the skills to coach and mentor. Mentoring and coaching future leaders is a complex mix of challenging, supporting, engaging, and planning. Whether an APN nurse is leading an organization, a policy change, or a quality improvement effort, they have a responsibility to build the capabilities of their team. Coaching and mentoring a leader's team members should be done strategically with purpose, vision, and commitment.

Building open, honest, safe relationships is how leaders help everyone develop their leadership capacity and that is the purpose of coaching and mentoring. The relational part of leadership requires a great deal of time, thought, and planning. Believing in and working with future leaders and providing opportunities for them to demonstrate competence and skills empowers them to lead. A coach/mentor leader must model the behaviors associated with a coach/mentor culture. This includes integrating coaching and mentoring into team meetings and individual meetings that give the message that you care about your team members and that you have their back. As a leader, sharing information about yourself such as your background, what drew you to work for "their" organization, and why it is important for you to be part of it will provide the basis for getting to know each other. Experience is how leaders grow. It takes time for leaders to mature. An effective leader recognizes that some people take more time than others to develop leadership skills and competence and that each person has their own specific leadership capacity.

20.2 Being a Coach and Mentor

Coaching and mentoring are frequently used interchangeably but they are different approaches to helping someone grow personally and professionally. Mentoring is a process where a person who is senior agrees to work with someone who is earlier in their professional development. The mentor is someone who has accomplished what the younger person wants to accomplish. The mentor serves as an advisor to the mentee and advocates for them to have specific experiences such as serving on a committee or board of a professional organization or within their organization, leading a quality improvement effort or assessing a specific care process. Mentorship relationships can be long term—a few even last a lifetime.

Unlike a mentor, a coach does not advise except on occasion when requested. A coach helps the staff define and clarify their own goals and strategies to attain them. Coaches ask powerful yet simple questions to help the staff member understand their goals and what helps or keeps them from realizing those goals. Neither coaching nor mentoring are counseling. See Table 20.1 for a summary of differences between coaching and mentoring.

A coach/mentor leader can change a culture by working with their team to create a productive and humanistic organization. Some leaders may think they have entirely too much to do to add coaching and mentoring to their responsibilities. Coaching and mentoring of others is not an add-on responsibility but a core responsibility of every leader worldwide. Many leaders do this in an informal way and are making explicit the responsibility of being the coach/mentor leader.

Leaders can integrate the elements of mentorship and coaching into how they work with individuals and their teams. The capacity to build relationships is based on many different factors including genetics, experiences, beliefs and values, knowledge and skills, and emotional intelligence. Not everyone comes to a leadership position with the ability to be a coach and mentor but being a coach and mentor can be learned through continuous awareness and practice (Maxwell 2004). An example of enhancing the ability to coach/mentor is to practice listening and being present to the person you are working with. Maintaining eye contact and taking several deep breaths periodically throughout a conversation will help to be present.

Leaders frequently feel that they have to solve all problems. It is often a challenge for leaders to step back and ask the team member how they would solve the problem. By asking team members to solve a problem, you are coaching them to be

Table 20.1 Examples of coaching and mentoring

Coach	Mentor
Questions help identify goals and plan	Expert provides advice to novice
One to one and/or team focus	One on one
Focus on the future	Connect to experts who will help further career
Partnership of working together to achieve goals	Arrange for educational experiences to further career
	Help negotiate the politics or an organization or situation

and feel more capable. If they get stuck, offer an idea and get them to think about possible solutions as opposed to telling them what to do or how to "fix it." In addition to the one-on-one meetings that provide coaching and mentoring opportunities, there are spot coaching opportunities. The Hudson Institute defines spot coaching "as just in time coaching that includes providing feedback, sets a goal, building a short plan and following up to provide support and track impact" (Hudson Institute 2019, para 2). For instance, a team member may pop into the leader's office to ask a quick question. During the brief exchange, the leader can address the question by asking what the team member thinks or what they would suggest to do.

Team members may need in-depth coaching and mentoring. Some team members are more likely to be future leaders than others and may benefit from working with a coach to focus on goals for specific high-level positions. Other team members who are not performing well may need coaching and mentoring to get back on track or to explore other options in terms of their professional goals. For instance, the faculty member who is at the program director level and has voiced their desire to be a more effective leader with a goal of being a dean or chief nurse would benefit from working with an experienced coach. Working with an experienced coach may help any team member in a leadership position to work on gaps they feel are compromising their abilities to lead.

20.2.1 The Coaching/Mentoring Process

A coach leader works with each team member and the team as a whole to assess the current situation and clarify their inspired future, help them build and execute a plan, and evaluate the outcome (McLean 2012). Being a leader means knowing how each person and team understands their current situation and goals for the future. What do they want to be doing in the next year, 5 years? Do they want to move to a higher-level leadership position or change the focus of their career? Some people know what they want as a career trajectory and others struggle to figure out which direction to go—administration, teaching, clinical service, research, or a combination—as well as how to enhance their abilities. Building an individual plan provides the roadmap to guide coaching and mentoring. See case example.

Case Study

Rebecca, a nurse practitioner, was passionate about caring for vulnerable populations. She had become a volunteer provider at a free clinic and shortly after she moved to a new town so that she could begin to network and get involved in the community. This clinic had a long and rich history of community and hospital system support and was full of compassionate people hoping to make a difference. Very quickly, her role expanded, as she was offered a paid position as the Clinical Director, a job that was robust, multi-faceted, and with limited

resources. Rebecca felt up to the leadership challenge and felt this was an opportunity to serve a mission that was dear to her heart. She learned very quickly, however, that she needed help navigating the community and board politics.

She reached out to a colleague who had enrolled in an executive coaching program and needed to practice coaching skills. Rebecca and her student coach began meeting regularly focusing on deep thought work to clarify goals for both her career and organization. Coaching provided an opportunity for Rebecca to talk through personnel challenges, to strategize about influencing the board, and be a safe harbor to listen to her struggles without judgment. As their coaching/mentoring relationship progressed, Rebecca grew in her confidence as a leader exploring her strengths and career goals with a long-term lens in addition to having to manage whatever challenge was in front of her. Rebecca was able to model the coaching skills she learned from her coach and found that coaching and mentoring her staff created a drastically enriched work environment for her team. Because of the coach/mentor, Rebecca was inspired to complete a doctoral program and start her own practice. As the two continue to meet, the coach sows seeds that inspire growth in Rebecca's life and career. Rebecca's incorporation of coaching and mentoring into her own leadership style has built a legacy that will outlast both Rebecca's and the coach's careers.

There are four important elements to keep in mind in building a plan: identifying obstacles, identifying strengths, developing awareness practices, and building new behaviors (McLean 2012). Identifying obstacles is critical. A frequent obstacle to achieving a goal is fear. The fear may be about failing to achieve the goal. For instance, a staff member may want to become a high-level executive nurse but has a great fear of speaking in public. The leader can help the team member address this fear in steps. First have the team member present to a small team of peers, then broaden the group to include people outside of the peer group and finally present at a meeting. Each of the steps needs to have an agreed upon timeline.

To identify strengths, ask team members to write down the strengths they believe they possess. Writing the strengths will help make the strengths more concrete and visible to the team member. Building self-awareness is critical inner work. Many leaders use external tools such as one of the many types of 360 assessments where colleagues, direct reports, managers, and others give feedback to team members about a variety of behaviors. However, not every leader can do this because of financial or other issues.

To help a team member achieve greater self-awareness, a coach/mentor should offer honest feedback, and encourage the team member to get feedback from others including colleagues, friends, and family. Attending educational or experiential workshops may be useful. The work for a team member is to identify and practice behaviors that are informed by their barriers and strengths, and self-awareness to achieve their goals.

20.2.2 Abilities of a Coach/Mentor

A leader needs to bring an intentional mindset of developing a person or team through coaching and mentoring. Being a coach/mentor does not mean that the leader abrogates their accountability for having effective team members. Being present with team members is critical to both listening as well as conveying your interest. No matter where you are in the world, health care has many distractions that makes staying present a challenge. In order to coach, leaders must practice careful listening to tone, context, and body language.

Today, many interactions are electronically based and it is important whenever possible to include video as part of the conversation in order to see facial expressions and body language. Some organizations, depending on connectivity capacity, are nearly solely virtual and it is important that leaders effectively use the virtual space to work with team members. Working with others by phone requires deep listening skills to hear nuances of tone, words, and context. Leaders need to use whatever medium they have to help their team member develop.

In addition to being present, a coach/mentor mindset requires knowing boundaries. One boundary is that coaching/mentoring is not counseling related to mental health issues. It is not appropriate to get into psychological or personal issues. If this is an issue, the individual should be referred to a counselor. Another boundary is knowing that the team member needs to own their work, not the coach/mentor. Leaders often want to step in and tell team members what they should do and how they should do it rather than empower their staff to solve problems.

There are some powerful questions that are relevant to both coaching and mentoring (Forbes Coaching Council 2018; Rodgers 2012). These questions help the team member reflect and take ownership of their goals and professional growth and also give the coach/mentor leader information to help guide the team member. These questions include:

What is keeping you from …?
What does success look like?
What will happen if you don't take this step?
Can you tell me more about …?
What do you need most right now?
What is most important in the world to you?
How does …. feel?
What can you do to achieve ….?

The challenge for the leader is to recognize when coaching is useful and when mentoring is useful. The integration means that the leader both supports the team member's defining their goals and plan coupled with providing advice and taking specific actions on behalf of the team member. Integrating coaching and mentoring will take practice and enhancement of the leader's self-awareness so that the interaction with the team member is intentional. An example of being both a coach and mentor is if a staff member presents a problem that she is having with the performance of nurse and rather than solving the problem, the coach could ask the staff

member how they would address the problem. As a mentor, the leader may suggest resources to manage the issue, ways that the leader has handled similar situations, offer suggestions for web resources to view.

20.3 Building a Coaching and Mentoring Culture

Building a coaching and mentoring culture institutionalizes a legacy. Clutterbuck and Megginson (2005) defines a coaching culture as "the predominant style of managing and working together, and where a commitment to grow the organization is embedded in a parallel commitment to grow the people in the organization" (p. 19). It takes changing the way people think about themselves and their leaders. The culture forms the basis of the norm for everyone to provide and receive coaching and mentoring.

To build a coaching/mentoring environment, a leader will need to consider the culture of the work environment and assess whether it supports a coaching/mentoring environment or not. Any coach/mentor leader needs to appreciate the history and values of an organization, recognize past accomplishments, know the impact of past leaders, and understand how the vision and mission can support a coaching/mentoring culture. An example of this is the newly hired nursing school dean who spends time understanding 50 years of history about the organization before setting the strategic priorities for moving the team forward. Without a clear understanding about past leadership, the culture within the organization, and the current challenges set before them, a leader does not have a clear understanding of how to lead the team forward to a future that sustains, enhances, and attains goals.

The most effective teams, according to Patrick Lencioni (2002) in his book, *The Five Dysfunctions of a Team*, are those in which members trust one another, engage in unfiltered conflict around ideas, commit to decisions and actions, hold one another accountable, and focus on the achievement of collective results (pp. 189–190). The cornerstone of an authentic coaching and mentoring culture is trust. Trust creates a safe environment for authentic interchanges of feedback and support that builds strong relationships.

Creating this environment in a healthcare setting is challenging. The work environment, especially an ineffective leader, is one of the most often cited factors causing nurses and other healthcare professionals alike to either become "disengaged" or leave their positions (De Keyrel 2017; Brusie 2019). Currently burnout and compassion fatigue are reported to be widespread among nurses (Sorenson et al. 2017). Connecting as a coach/mentor to your team fosters humanism, awareness, and mutual understanding that can decrease burnout and increase engagement (Privitera 2018). These issues make developing a culture of mentoring and coaching even more compelling.

Establishing a culture that builds self-confidence in problem-solving and in which the contributions of team members are valued has increased employee retention and satisfaction (Dempsey and Reilly 2016; Gartenstein 2019). This type of

"organic system" is inherently change-driven and keeps highly talented human resources engaged and renewed so that the organization can flex and adapt successfully (Kontoghiorghes 2016). In the ever-changing healthcare environment, having an adaptable team is highly important.

20.3.1 Understand the Challenge

Leaders often feel that it is important to "make their mark." They are expected to reach certain goals and bring change that will create a more productive organization. Today's culture is one of short-term wins based on quarterly reports, but experienced leaders know that to produce results, often the culture must change which takes years. Creating a culture of coaching and mentoring requires a plan. All staff need to be involved in creating the plan. Questions that help create the plan include: What do the team members think could be improved within the organization? How do they define a coaching and mentoring culture? The goal to is to create and maintain an environment in which coaching and mentoring can flourish, new ideas are nurtured, team members feel safe to bring up difficult issues, and employees feel their contributions are valued.

The plan should identify specific goals and activities as well as a timeline and the person responsible for completing the work. They will need to understand the "why" of creating a coaching and mentoring culture. The leader can provide an initial rationale, and then ask the team to provide additional reasons why this process would be important to them and their work. Anticipating possible problems with implementation should be part of the plan as well as developing evaluation criteria. The process needs to be transparent with everyone knowing the content. As part of the plan, consider how coaching and mentoring will be done internally. How will this be set up initially and then long term? If resources permit, consider bringing in outside mentors and coaches as part of the plan.

One of the most effective ways to implement culture change is to help each member of the team understand their role in the plan and how the plan will impact them and others in the organization. Coaching team members to enhance their abilities of critical thinking, prioritization, or proactive planning will assist in implementation. Addressing learning needs related to culture change will help move change forward.

To effect culture change, leaders have the responsibility to thoughtfully provide experiences to team members either through supporting educational experiences and/or role modeling. To address fear of change, leaders can ask team members how they believe the culture change will affect their job or department and then coach and mentor them through their fears. Staff may often feel uncomfortable and unprepared to provide coaching or mentoring to others or from others. The culture change will empower the team to grow in their ability to consider problems in a more dynamic way and create solutions that move everyone forward together.

Team building is important to a coaching/mentoring culture and can occur in a variety of ways from activities built into staff meetings to off-site retreats. Regardless

of budgets or time commitments, placing high priority on fostering cohesiveness and mutual understanding is key and can include gatherings outside of the work. Knowing each other more personally helps to create trust, foster engagement, and reduce burnout and feelings of stress. There will be a better understanding of roles as communication is enhanced among team members. In a coach/mentoring culture, team members will help each other to solve problems and grow professionally.

While having a job serves many of our needs—financial, meaningful work, adding something good to the world, having relationships, we often choose a job for its mission and core values. Questions about what the envisioned culture means to each of your team members can be useful in understanding the link between their values and beliefs and the implementation of coach/mentor culture. Setting expectations about the implementation and expected benefits and challenges is a critical part of implementation. Be honest with your team by keeping them updated on the status of the change as measured by established benchmarks. Having the team understand the full picture of the change and engaging them in problem-solving will help to continue the implementation of change. Transparency prepares the way for the coach/mentor leader to inspire new ideas and directions. A coaching/mentoring culture can facilitate the recognition of a job well done regardless of budget and infrastructure. Recognition can enhance job satisfaction, and professional and personal growth that are major factors related to retention (Cloutier et al. 2015).

During implementation, a particularly important element of a coaching and mentoring culture is for the leader to role model conflict management. No matter the pressure a leader is under, the leader treats people justly and consistently with the utmost professionalism. Role modeling conflict management may require scheduling "time outs" during the day to collect your thoughts, check your emotions, blow off steam, take a walk or do whatever it takes for you to be able to maintain professionalism with your team. When a conflict among team members arises and is brought to your attention, recognizing the emotion related to the conflict is a first step. There may need to be a cooling down period, but addressing the issue as soon as possible will keep the issue from festering. This approach gives everyone involved the opportunity to allow emotions to settle, yet address the issue in a timely way.

Implementing change requires engaging leaders of your team. Every team member is a leader with some being informal leaders and others having formal titles. It is important to understand the dynamics of the team as they can influence how you introduce change within your organization. Who is the most vocal in meetings? Who comes to you with problems most frequently? Who seems to be able to garner group buy-in? If the informal and formal leaders support your goal of developing a culture of mentoring and coaching, building this culture will likely have a smooth trajectory with the larger group.

Staff may think that changing a culture disrespects a past leader. Never make negative comments about previous leaders. Negative talk about previous leaders is contrary to building the trust necessary in a coaching and mentoring culture. It will alienate those who were a part of the previous leadership.

20.3.2 Evaluation of Culture Change Through Shared Accountability

Each team member needs to know what she/he is accountable for achieving and reporting back to the team. If they need help, they can trust that they can ask. You and your team can evaluate the progress in adopting a coaching and mentoring culture by being aware of the communication patterns, how team members engage in conversations, and how they solve problems.

Evaluation can include doing a survey of all staff asking do they: (1) feel safe to raise issues; (2) find coaching feedback useful; (3) feel that the leader provides opportunities for growth; (4) provide constructive feedback to others; (5) value the environment and want to stay; and (6) recommend the organization as a workplace. If resources permit, there are consultants available to help with a formal culture evaluation process. Evaluation of the culture should be done every year to identify units that may need more attention to develop the culture.

20.4 Conclusion

A meaningful legacy of current leaders is to build future leaders through mentoring and coaching. Building a culture of coaching and mentoring is critical to empowering and developing the APNs to continue to provide access, affordable, high quality patient care. Having an empowered team will create a more effective, dynamic and human focused organization. It is the people in an organization who produce outcomes and those outcomes benefit the patients that APNs serve worldwide. Creating a coaching and mentoring culture can be done in any country in any organization with the support of the leadership. Embracing the actions and philosophy of a coaching and mentoring culture can change a culture and our healthcare system to benefit all.

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Collaborative Leadership by Consensus Building

21

Maria Consuelo Cerón

21.1 Introduction

Advanced Practice Nurses (APNs) have proven to be strategic providers to drive Primary Health Care (PHC) in a highly cost-effective, safe and quality way in countries like the United States, Canada, and the United Kingdom among others. A compilation of systematic reviews shows that nurses working in advanced roles such as the nurse practitioner provide at least an equivalent quality of care compared to general practitioners/physicians. Furthermore, the evidence suggests that the care delivered by APNs reduces readmissions and achieves greater patient satisfaction, especially in patients with chronic conditions (Maier et al. 2017; Laurant et al. 2018). However, in Latin American countries, the APN is an unknown or relatively new concept, although some nurses with bachelor's degrees are assuming advanced roles beyond their scope of practice in order to address the population's health needs. The gap in the education, training, and regulation of these nurses has been addressed by the Pan American Health Organization, which has been encouraging countries to implement APN roles in PHC in order to achieve Universal Health (Cassiani et al. 2018).

In the following chapter, we will describe the case of Chile in the development and implementation of the APN role through collaborative work among universities and consensus building about the definition, competencies, scope of practice, and APN master's programs.

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21.2 A Little Bit About Chile

Chile is situated in the southwestern tip of South America between the Andes Mountain and the Pacific Ocean. Geographically speaking, it is a long and narrow country, which measures about 4300 km from north to south and extends to about 8000 km when the Chilean Antarctic is added. In terms of width, Chile at the narrowest point of the country measures 90 km, while the widest point is located in the north of the country and takes about 3 h to travel by car from sea to mountain range. Chile's geography includes a huge variety of landscapes and climates throughout its territory, from the Atacama Desert, the driest in the world in the far north, to Patagonia's millennia-old glaciers, in the very south. In general, Chile is divided into three large geographical areas: north, central, and south. The climate of the north regions is mainly dry and hot and the big cities are located on the coast, while the central zone is temperate, with a Mediterranean climate that determines a high population density in cities that are located mostly on the different valleys of the area. In the southern region, the climate is cold and rainy, which leads to an abundant and diverse flora and fauna. From the economic point of view, Chile is a developing country, with a mixed economic system between the free market and the state. The gross domestic product (GDP) for 2019 is projected to be USD 300,000 and the per capita average is USD 25,000 with great variability of economic activity taking place in each region. For example, the Antofagasta region in northern Chile has the highest per capita GDP due to mining while the Araucanía region in the south has the lowest per capita since economic activity is based mainly on agriculture, livestock, and forestry industry. The population is mainly concentrated in urban areas such as Santiago, the capital of Chile, which has the highest population density at the national level. On the contrary, vast tracts of land have low population density such the north and very south regions.

21.3 Chilean Population and Health Issues

The Chilean population is about 18 million inhabitants, whose main race is mestizo, mixed between native American people and Spanish colonist ancestry. During the last century, Chile received European immigration from countries such as Spain, England, Germany, Italy, and Croatia. However, this immigration was never on a large scale, contrasting with mass migrations that characterized other countries like Argentina, Uruguay, and Brazil. In recent decades, immigrants have come from Latin American countries such as Argentina, Peru, Haiti, Colombia, and Venezuela, attracted by the economic and political stability. Currently, the percentage of immigrants corresponds to 6% of the population.

The last National Population Health Survey 2016–2017 reveals that Chile is in a situation of low protective factors and high prevalence of risk factors for noncommunicable diseases such as high prevalence of tobacco consumption, sedentary life style, and overweight and obesity. Therefore, the main health issues are diabetes, hypertension, and cancer (Ministerio de Salud-Chile 2017a). Moreover, Chile is

also facing a rapid aging of the population due to an increase of life expectancy and low birth rates. These demographic changes are accentuated in some regions of the country due to the difficult access to health care.

In the Chilean health system, the public and private sectors coexist. The public health insurance covers around 70% of the population, basically the urban and rural population belonging to the lower-middle class, and retirees. The financing of this system is administered by the National Health Fund and the provision of care is ensured by the National Health Services System and the Municipal System for Primary Care. A small proportion of the Chilean population, around 10%, is covered by other public agencies such as Army Health Services or university hospitals. The private sector covers the 20% of the population belonging to the upper-middle class and includes the private health plans administered through the Health Provision Institutions and private insurance administered by insurance companies. The provision of care is by private hospitals and private care centers. A parallel private system exists for occupational diseases; three not-for-profit insurance companies provide health care to more than 2.5 million workers.

Regarding Human Resources in health, both nurses and physicians are required to complete a university level undergraduate program with high quality standards. However, during the last three decades Chile has seen a great increase in the university enrollment with the entrance of private universities to the educational market. Although more universities offer programs for nurses and physicians, there is still a shortage of these professions in some regions of the country (Ministerio de Salud-Chile 2017b). On the other hand, nursing and medical curricula were focused on illness and the health system's resources were appropriated mainly to build and manage hospitals. Recently, a great concern has emerged about the need to change the focus to strengthening the PHC with greater emphasis on health promotion. But, for many nurses and physicians, hospitals are still being more attractive for career advancement.

From a socio-anthropological point of view, the care model is still paternalistic with an asymmetric relationship between patients and the health team. Nevertheless, since 2012 a Patient Rights Law was passed that looks for a more patient centered care model. In social, communicational, and political context, physicians have an important influence. Finally, the feminist movement around the world has been gaining strength also in Chile, revealing the gaps and inequities between salaries and the chosen careers among women and men. At a national level, the service careers such as nursing are still mainly female careers.

21.4 A Little About Nursing

Chile has 45 universities with undergraduate nursing programs and its university enrollment is one of the highest in the system, with almost 41,000 students. Specializations in nursing do not have formal recognition by the Ministry of Health and therefore do not have state scholarships or economic compensation from the employers. On the other hand, there is an important variability among nursing

specialties, in terms of names and curricular requirements. On average, a nursing specialty contains 120 h of theoretical courses and around 800 h of clinical practice. The variability in terms of names and curriculum requirements has made it difficult to reach a national consensus on the different specialties in order to achieve the needed formal recognition. The most important nursing organizations are the Chilean Nurses Association and the National Federation of Associations of Nurses of Chile in the political and union side. In the academic area, the Chilean Association of Schools of Nursing (ACHIEEN) brings together the oldest 24 leading schools of nursing in the country as well as some important scientific societies such as the Chilean Society of Intensive Medicine-Nursing Division, the Chilean Society of Nursing in Dialysis and Kidney Transplant, the Chilean Society of Nursing in Cardiology and Vascular Surgery, and the Chilean Scientific Society in Nursing of Children and Adolescents.

21.5 How APN Development Started in Chile

The first ideas about APN in Chile started in the late 90s when the School of Nursing of Universidad de los Andes thought it was the right time to develop graduate programs. An important aspect that was taken into consideration when thinking about what types of graduate program to develop, was the need to strengthen programs aimed at clinical nurses to improve clinical practice and patient outcomes, since, to that date, there were only programs with academic focus addressed mainly to faculty nurses with the purpose of generating research around nursing science. Because there was not a local APN program, the first step was to send a faculty member to study in an APN program at New York University during 2001–2003. On her return, she was charged with developing our own APN master's program. The US curriculum and model of APN was used as a reference point, particularly focusing on CNS role, because it was more suitable to the Chilean health system which centered on hospital care. As a part of the project, in 2009 two nurse faculty visited University of Pennsylvania, University of California San Francisco, and Johns Hopkins Nursing School in order to learn about their experiences running APN programs. As a result of this work, in 2012 we launched the first program in Chile and Latin America of APN with six students.

The invitation to participate in 2015 at the Universal Access to Health and Universal Health Coverage APN summit organized by PAHO and the School of Nursing of McMaster University, inspired the leaders of the program to implement the NP role focused on primary health care. This meeting was crucial to speed up our efforts regarding PAHO's requirement. The summit's conclusions have guided the steps in this challenge. The main successes reached have been to establish a network among 11 nursing schools through Chile in partnerships with Chilean Association of School of Nursing. The main goal of this network is to generate an alliance within PAHO-Chile, the Ministry of Health, and the Chilean Association of Nurses, to work together implementing the NP role in primary health care.

21.6 Following the Main Outcomes From PAHO Reports

As was mentioned previously, in 2015, PAHO invited our School of Nursing to "Universal Access to Health and Universal Health Coverage: Advanced Practice Nursing Summit," organized by PAHO and the School of Nursing of McMaster University, given that Universidad de los Andes was the only University in Latin America that had an advanced practice nursing program. At that summit we committed ourselves to implement the strategies and next steps suggested by the summit. After the summit, we organized a work team within our School of Nursing in order to review the references suggested by the experts met in Canada and we defined an action plan with three objectives in mind: (1) Involve relevant stakeholders and generate a work team, (2) Define the priority health needs that the APN could impact and (3) Encourage the development of APN programs in other universities. Among the priorities suggested by the report, a key recommendation was to "involve and influence decision makers, legislators and other key stakeholders." For this reason, one of the first things we did was to meet with the Chilean Association of Schools of Nursing (ACHIEEN), which includes 24 accredited and prestigious nursing schools in the country. In conjunction with the ACHIEEN we established an expanded council, where the Schools' Directors participated, to present the summit report and its results. The purpose of this council was to involve as many people as possible to increase the work team and cover more regions of the country. After this council, the Nursing Network of Advanced Practice Nursing for Primary Health Care was formed, with representatives of schools in the northern, southern, and central areas of Chile. This network is housed in the ACHIEEN, with its own organizational chart and definition of specific goals and tasks. Together with the network, we planned three summits to replicate those of PAHO-McMaster, one in Santiago, other in Antofagasta (north) and Temuco (south). At each summit, nurses from PHC and from nursing schools in the primary health care area were invited. The purpose of these meetings was to make known the definition, competencies, and the scope of practice of the APN role, identify the main health problems of the population and to visualize the impact that the implementation of the APN could have on PHC.

In parallel, we held meetings with key actors such as the Chilean Nurses Associations, the Chilean Medical Associations, the Association of City Councils, and the National Confederation of Municipal Health. The priority number 2.1 points to the relevance to have a speech about the PAHO resolution N° 52. For this reason, a series of letters to the director of the main national media were written. Because of these letters, we gained visibility and were contacted to write a publication in the *Medical Journal of Chile*, in a Bulletin of the Center for Public Studies and to participate in the Edition of the Propuesta de Modernización y Fortalecimiento de los Prestadores Estatales de Servicios de Salud of the Centro de Políticas Públicas and the Escuela de Salud Pública Universidad de Chile. A chapter in this last document, a Model of Health Care of state providers, a new role configuration is proposed within the health teams, based on the delegation of tasks by competencies. This model is highlighted as especially relevant for PHC and here the NP is presented as

a successful example with the evidence that supports its benefits in PHC (Centro de Estudios Públicos-Escuela de Salud Pública Dr. Salvador Allende Universidad de Chile 2017). During the development of the different strategies, we reinforced the importance of collaborative work and networking. The interaction that takes place between the different members of the group and the different views of the same problem undoubtedly enhanced the synergies and the final results. The objective to involve the nursing schools for the implementation of the APN in Chile has been a successful joint effort in pursuit of the implementation of APN role. However, we still need to involve the nurses more actively, especially the Chilean Nurses Association. We have not yet achieved the implementation of this role and have yet to see its positive impact in PHC. Work is still needed to be done for the Chilean Association of Nurses to see the APN role development as a relevant objective for their organization, as well as for the clinical nurses in general and the scientific nurses' associations. Moreover, the scientific societies of nursing have seen the APN as a threat, since many experienced nurses and specialists in our country work in some areas of the advanced role and have already developed expert knowledge in certain areas and have acquired certain skills and leadership over the years. They have done this generally without the formal training of a master's degree program that considers other advanced practice competencies such as evidence-based practice or pharmacology. Nevertheless, the APN has generated much interest within some scientific nurses' societies. For example, advanced practice was a topic within the most important national conferences, generating a stimulating discussion about the role. The greater visibility of the APN led us to be invited to participate in the Ministry of Health Cancer Advisory Commission to present a proposal on the contribution of the APN in Oncology for the National Cancer Plan 2018–2028. This work allowed us to be present in the discussion on the advanced role at the ministerial level, opening the possibility that the ministry supports the formation of APN in oncology. Also, at the ministry level, leaders had a glimpse of the potential for this new nurse role to address other critical public health needs that exist in our country, such as with the patient with chronic kidney disease, the follow-up of diabetic and hypertensive patients, palliative care, and mental health among others. Following with the contribution of the APN in oncology in the national cancer plan, we organized an expert work team made up of academic nurses, clinical nurses with experience in oncology, and an expert in regulations and health law matters. As a work team, we agreed on important definitions for the development of the APN in Chile based on the consensus model and the guidelines from the International Council of Nurses. For example, we agreed on one definition of the APN concept for Chile, we designed the curricula for the master's program of Advanced Practice in Oncology with its corresponding graduation profile, based on seven competences that we established as priorities for the current national context. In the design of the program, we considered two pathways: a four semester program with at least 800 clinical hours for nurses with more than 3 years of clinical experience and an accelerated program of two semesters with 300 clinical hours for experienced nurses or specialists in oncology with previous recognition of the competences through an exam to gauge their knowledge and skills and the expert knowledge in the area of oncology.

Finally, another important aspect in which the team has worked is to define the role that the APN would have within the oncology team and its scope of practice, distinguishing it very clearly from the registered nurse, the nurse specialist, and the oncologist.

21.7 Next Challenges

From the work of these years, the APN has been added on the agenda of several groups, including the Ministry of Health. The APN role is one subject on the national conferences of different scientific societies, which are interested in the impact that APN could have within its specialties, such as critical care, oncology, and nephrology. However, we must develop strategies to involve the scientific nurses' societies and to be part of the work of the universities in the implementation of the APN since it is necessary to give space to the experts or specialists who have felt threatened with the advanced roles in nursing. Likewise, it is necessary to gather nurses from the academic and union associations under the same objective to implement the APN in PHC and in other critical health problems such as patient with cancer.

Regarding the regulatory framework, it is necessary to move forward elaborating protocols and guidelines that support the APN role and allow these nurses to perform safely, especially with those matters related to the prescription writing, treatment of diseases, requests for laboratory tests, and referral to physician specialists, among others. In parallel, it is necessary to participate in the commissions at governmental level that are studying a change in the sanitary code, which regulates the health professions.

Within the future challenges, it is very important to define very well when and how to measure the impact of the APN in oncology in order to generate national evidence that allows the role to be expanded to other critical areas.

Finally, we must generate alliances with regions to solve their problems by breaking the geographical barriers of our country. The universities that have been protagonists in the implementation of the APN are located in Santiago, where there is a greater concentration of physician specialists and the gaps in health access and coverage is less critical than in the rest of the country.

21.8 Conclusions

For the implementation of the APN role in our country, we have followed the service leadership style, which allows leaders to manage changes by spreading and sharing a common purpose with a sense of mission. Once the collaborators are identified and this common purpose is clear, the leader facilitates and focuses on "how" to achieve that purpose. However, the key characteristic of this style of leadership is that the leader considers himself "the first among a group of equals." That is, this leader does not visualize himself above those he leads, but instead the first among several. Being part of the team that leads, allows them to promote the

fellowship, the synergies, and the learning between partners. This idea, which is at the very heart of service leadership, has allowed us to gather teams around the implementation of the APN and reach a common language to appeal to decision makers and stakeholders.

Also this style of leadership enhances the formation of teams, since the leader identifies and resorts to the strengths of its collaborators and is able to become one more when the situation demands. This process allows each member of the team to do what they do well by strengthening each one's abilities and allowing them to shine on their own. Likewise, the creation of work teams favors collaborative work, that is to say, a group of people who trust in collective collaboration and in the work of the other, so that each member experiences the greatest success and achieves its objectives more widely in favor of the common goal.

This concept is reflected mainly in the collaborative work between universities, which has been fundamental, since it has allowed us to enrich the proposal with different visions and establish working networks both at national and international levels. Likewise, this collaborative work promotes identification and training of future generations who will lead this project. Finally, we have taken this challenge with a transcendent outlook, that is, with a long-term perspective that allows us to put projects above personal leaderships and directs all our efforts and knowledge towards a common goal, the implementation of the APN at the national level. We also intend that this be a sustainable project that lasts over time, for this it is essential to document all the work done, develop clinical guidelines and protocols, and generate research to evaluate all the processes, including the evaluation stage. Finally, we hope to build a solid base for the future of the APN role in Chile.

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Leadership Through Entrepreneurship

22

Laure Marino, Aila Accad, and Taura L. Barr

Entrepreneurship is the process of creating value through creativity and innovation to make a sustainable impact. To be entrepreneurial is to recognize the importance of creating something that is innovative, is useful and has the potential to transform the current standard. An entrepreneurial mindset enables you to make an impact regardless of what position you hold or where your career takes you. Being innovative is a natural function of nursing; we are problem finders and problem solvers. The creativity we bring to solving the problems is the nursing process at its core.

Some nurses will take their innovation to bring new goods and services to the market—this is nurse entrepreneurship. Other nurses will use their knowledge to effect change and growth in their current position. This is known as being an intrapreneur, seeing a gap, and leveraging existing resources of the institution to create local change. Worldwide we have seen the expansion of "Innovation Centers" in the healthcare delivery system, recognizing that nurses, creative problem solvers, are the key drivers to system change resulting in better health outcomes and cost savings.

The REshape Innovation Center at Radboud University Medical Center in the Netherlands is one such example. Shawna Butler, RN, MBA is the EntrepreNURSE in residence, bringing the nurse perspective to early-stage ventures, large-scale enterprises, and to new emerging and converging technologies. The international company, Johnson and Johnson, has launched a comprehensive innovation

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platform, with programs that focus on advancing nurse-led innovation (https://nursing.jnj.com/innovate-with-us).

MakerNurse (http://makernurse.com/) sponsored by the Robert Wood Johnson Foundation is a community of inventive nurses who are creating solutions to improve patient care every day. Nurses are supported with tools and training to create a new generation of healthcare technologies.

Both nurse entrepreneurs and nurse intrapreneurs are needed to transform our healthcare delivery system. Indeed, there is overlap in the skill set of the entrepreneur and intrapreneur. In this chapter, we will focus on nurse entrepreneurship examining opportunities for new business development based on social trends and provide practical guidance that nurses need to be successful entrepreneurs. If you are reading this chapter and thinking *I will never be an entrepreneur*, we urge you to think again. It may be true that not all APRNs are entrepreneurs, so, too is it also true that we must expand our thinking on nurse entrepreneurship, build skills and embrace the profound impact entrepreneurship has on nursing practice, the nursing profession, and people who need nursing care.

Nursing entrepreneurship—often termed private practice, independent practice, independent contractor, and self-employed practice—sees the nurse as "a proprietor of a business that offers nursing services of a direct care, educational, research, administrative or consultative nature. The self-employed nurse is directly accountable to the client, to whom, or on behalf of whom, nursing services are provided" (ICN 2004, p. 4). Leadership through nurse entrepreneurship increases autonomy in practice, advances professionalism and will transform the healthcare delivery system (Smith et al. 2015).

Global estimates indicate that less than 1% of working nurses are business owners (ICN 2012). There are several plausible explanations for this phenomena. Economic conditions may contribute to this low number. Seventy-eight percent of all countries offer free or universal health coverage, typically funded by taxes (InternationalInsurance.com, n.d.). Most nurses in these countries are employed by agencies that provide healthcare services. However, countries with national health insurance also vary in the type of services provided; often citizens purchase supplemental insurance or pay cash to ensure an appropriate standard of care. Thus, worldwide there is still opportunity for nurse entrepreneurs to launch businesses to meet gaps in healthcare, and to receive payment for their services.

Many other compelling reasons may explain the low number of nurse entrepreneurs. Nursing school curricula typically do not include business principles, and when they do, it is featured at the doctoral level. While not all APRNs will be entrepreneurs, entrepreneurship is not limited to APRNs or those who achieve an advanced degree. There is a dearth of research on nurse entrepreneurship. Most reports contain anecdotal summaries or are guidebooks with tips to successful practice. In addition to economic factors, legislative and political factors may impede entrepreneurship. Over-regulation, restrictive scope of practice, and sub-optimal reimbursement are all policy concerns that can negatively impact the viability of a healthcare business. In order to increase the number of nurse entrepreneurs and to demonstrate the impact of nurse entrepreneurship, system change must occur.

22.1 Introduction

Most countries realize that their economy depends on a robust small business sector. In his article, *Six ways countries can support entrepreneurship*, University of Western Australia Professor Tim Mazzarol wrote that the heads of state attending the G20 Leaders' Summit meeting in Brisbane, Australia had called for enhanced efforts to grow economies through innovation and entrepreneurship (Mazzarol 2014). The European Commission (2003) noted that entrepreneurship is an important driver for economic growth, competitiveness, job creation, and a means to resolve social issues, including the escalating cost of healthcare.

Recognizing that women-led business represented untapped potential and that women have often been subjected to numerous hardships, the International Labour Organization launched Women's Entrepreneurship Development and Gender Equality (WEDGE) to address the practical needs of women entrepreneurs, to remove the socio-cultural, legal and political barriers for women's entrepreneurship, and to advocate for an enabling environment for business development and gender equality (ilo.org, n.d). And in the United Kingdom, the Department of Trade and Industry Small Business Service stepped up efforts to increase female entrepreneurship, creating a strategic framework to support expansion of these businesses (DTI 2006).

In the USA, the State Department created the Academy of Women Entrepreneurs (AWE). Also originating in the USA was a sentinel policy report, issued by the Institute of Medicine in 2010, *The Future of Nursing, Leading Change, Advancing Health* (IOM 2011). This report has changed the healthcare landscape in America by leveraging the largest and most trusted profession of nursing (Brenan 2018) to transform a crippled healthcare system. Two key ways this is occurring is through an increased emphasis on nurse-led innovation and nurse entrepreneurship.

While we believe that entrepreneurship represents the future of nursing's untapped potential, we have also observed that nurses feel ill equipped to translate their knowledge into innovative processes or to the private sector to open their own businesses. Traditionally, nursing students are primarily focused on learning the clinical skills of diagnostic reasoning; however, this dynamic is changing.

More and more students, particularly millennials, are seeking out opportunities for innovation and entrepreneurship. As a profession, we need to be equipped to provide these opportunities or risk the possibility of losing these students to other programs. We agree with the IOM recommendation that influencing nurses at the beginning of their career likely has the greatest impact on future entrepreneurial activity.

Nursing education has not emphasized the importance of nursing innovation. Thus, nurses do not often see themselves able or equipped to innovate. Nurses tend to view themselves as employed providers of healthcare, rather than leaders in the business of health, as either an intrapreneur or entrepreneur. This mindset is slowly changing as nursing education begins to incorporate business principles into the curriculum and nursing leadership embraces its role in this culture shift.

The good news is that entrepreneurship is not an inherited or genetic trait. The skills can be learned! In this chapter, we explore benefits and barriers to entrepreneurship and suggest strategies to expand the foot-print of nurse business owners.

22.2 Turning Innovation and Creativity into Entrepreneurship

Nursing is an art. We have all heard this, but what we do not recognize is that owning our creativity is inherent in that phrase. Artists are creative by nature. They do not see things for what they are, they see them for what they could be. This mindset is at the heart of innovation. As a nurse, you use your creativity every day. By leveraging that creativity, you can create well beyond what you think is possible.

Nurses have been innovating in healthcare since Florence Nightingale. Examples of early nursing innovations include the Henry Street Settlement in the USA, established by nurse Lillian Wald in 1893, and the Frontier Nursing Service established by nurse Mary Breckinridge in 1925. Wald and Breckinridge were examples of nurse innovators who created opportunities for nurses to practice independently within an organized nurse-managed setting.

Dame Cicely Saunders of the United Kingdom founded the modern hospice movement. Contemporary nurse entrepreneurs include Anna Sort, of Barcelona, a specialist in Digital Health and Gamification, who has founded two digital healthcare companies. Her products bring new technologies to patients and nurses to improve care. Tiffany Kelley, of the USA, is a nurse inventor and owner of **Nightingale Apps**, a mobile health technology company that provides digital solutions to nurses to support their care delivery needs.

There are countless other examples of nurses who saw a need, created a solution and changed practice to make it happen. You can too.

An entrepreneur is someone who organizes, manages, and assumes the risk of a business (Merriam-Webster 2016). The heart of entrepreneurship is a curious mind, a mind that finds solutions to problems. Entrepreneurship is about seeing a need and filling it.

Nurses in administrative practice have skills in managing personnel, time, budgets, and other business skills. All nurses use the nursing process including assessment, identification of needs/problems/gaps, interventions, and evaluation measures to improve patient care and outcomes. These are also skills of effective entrepreneurs.

Some common qualities of entrepreneurs include being resilient, motivated, accountable, honest, passionate, goal oriented, curious, comfortable with uncertainty, able to take risks, enthusiastic, critical thinking, assertive, creative, able to thrive on change, able to handle stress, self-confident, and willing to collaborate. Hopefully, right now you are thinking, *"I see these qualities in myself—and the nurses around me."*

Healthcare is changing, and the nurse entrepreneur is forward thinking, recognizing the requirements of a changing system well in advance of when the need

arises. Healthcare of the future is person-centered, authentic, based on experience and value driven. Because nurses already practice via science and art, we are perfectly positioned to blend compassionate, heart-centered care with sustainable creative businesses. As nurses take center stage in healthcare transformation, they will be encouraged to think beyond the patient to greater impact, sustainability, and growth, all of which are critical components of an entrepreneurial mindset.

22.3 Trends Supporting Nurse Entrepreneurship

No matter what business you are involved in, success is primarily dependent on providing a necessary service or product. Who drives this? Consumers. Savvy entrepreneurs must understand their population and what it is that they want or need. Population trends and policy changes are two significant factors entrepreneurs must consider.

22.3.1 Population Trends

People worldwide are living longer. Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12 to 22% (WHO 2018). Worldwide, 125 million people are aged 80 years or older. By 2050, there will be almost this many (120 million) living in China alone, and 434 million people in this age group across the globe (WHO 2018). In the USA, nearly 10,000 baby boomers turn 65 every day! This has been happening every day since 2012 and is projected to continue for another 20 years (Pew Research Center 2010). Japan is experiencing a "super-aging" society both in rural and urban areas. According to 2014 estimates, over a third of the population is 60 years or older (ILC-Japan 2013). While longer life brings with it, opportunities, not only for older people and their families, longer aging also challenges countries to ensure that their health and social systems are ready to make the most of this demographic shift.

Older consumers need personalized attention for chronic care management including coordinating multiple providers, medication management, loneliness, and cost concerns. Previously, multigenerational households used internal resources to care for elders. As jobs shift to larger cities and families are increasingly separated by geography, adult children need more resources to meet the care needs of their parents (Elango et al. 2007). Many elders suffer from mobility-related problems, creating opportunities for nurses to offer mobile services. A relatively wealthy, aging population is willing to pay for services delivered to them at home, or improve their access to a clinician, as is typical in a concierge type practice. As people live longer, we see a shift to creating enhanced quality of life after retirement. Each of these factors translates to a host of new business opportunities for nurses.

At the other end of the age spectrum are Millennials (born between 1980 and 1994) and Generation Z (born in the mid 1990–2000) who are changing everything—from the way we shop, eat, travel, and even access healthcare. Generation Z represent 32

million of the global population, with Millennials, another 31 million. In the USA, these younger groups far surpass the Baby Boomers (Miller and Lu 2018). What are the unique features of these consumers? Most significant, wrote Morris Panner in Forbes magazine, is that they have grown up in a technology powered, consumer-oriented environment, with high expectations of efficiency. They value convenience, transparency, and rapid delivery of services. They get their health information from the internet and no longer rely solely on a healthcare provider to answer their questions. They want to know what they are buying and how much it costs (April, 2019). Their culture of health values nutrition and exercise over antibiotics, promotes mental healthcare through expanded services, and includes an increasing awareness on gender fluidity and social tolerance (Global Marketing Group 2019).

The Millennials are also responsible for what might be called a new Baby Boom. An analysis of US census data showed that motherhood and overall family size are on the uptick (Bednar 2018). New business opportunities that harness technology and easier access to care will have traction with younger consumers. Retail clinics, evening hours, drop in clinics, and published prices for care are all important care delivery trends that are the result of shifts in consumer needs and wants.

With all that is good about technology, we also know consumers crave balance of high touch with high tech. Nurses, rated as the most trusted profession for nearly 20 consecutive years (Brenan 2018), are perfectly positioned to balance high tech with high touch, personalizing care within a context of evidence-based information and advocacy. Nurses can be the bridge between the patient and technology, helping consumers to use technology to better their health.

22.3.2 Policy/Workforce Trends

Radical changes in healthcare reform brought about by the Patient Protection and Affordable Care Act (ACA) in the USA, brought upwards of 20 million people into the healthcare system, clamoring for services and access to providers (ASPE 2016). This massive influx not only increased the demand for clinicians but also for a broader variety of goods and services. Entities that could rapidly respond to the policy impact of the ACA benefitted the most. Since a primary care physician shortage existed long before the ACA was passed, the medical establishment has been less able to react quickly or adequately to meet the demand for providers (AAMC 2019). On the other hand, the nursing profession provided a ready solution, increasing the supply of advanced practice nurses. By 2018, APRNs were providing over one billion heath care visits annually with nearly 90% of all Nurse Practitioners (NPs) prepared in primary care (AANP 2019). APRN care outcomes are shown to be equal to or better than the same care provided by physicians. Patients report a higher satisfaction with APRN care, and they adhere better to the treatment plans they design with an APRN (Stanik-Hutt et al. 2013).

Indeed, the healthcare landscape has changed with APRNs providing high-quality cost-effective care, in retail clinics, home/mobile practices, and the

community. Consumers are experiencing APRN care and they like what they are getting! While some states in the USA still have work to do to remove onerous practice barriers for APRNs, the environment is rich with opportunities for nurse-owned businesses to meet the need and population trends.

22.4 What Nurses Need to Lead as Entrepreneurs

All nurses are leaders, regardless of the particular position they hold in the health-care system. Seeing yourself as a nurse leader is a mindset, as is seeing yourself as a nurse entrepreneur. Nurses need to know they have the ability to lead change, be business owners, and create new models for health delivery. How does this happen? By changing nursing culture, by incorporating business skills into nursing curricula and creating business cultures that support innovation.

When schools of nursing support innovation and entrepreneurs, they not only influence current nurses, but also engage the next generation of nurses. When you see entrepreneurship happening, it becomes real and normal—not an outlier role. While schools have expanded their curriculum, we note a definite trend toward skill development for the nurse executive in a hospital setting or C suite, rather than on business development.

Some programs, however, truly embrace nursing innovation. For those thinking about this career path, we suggest checking out The Ohio State University School of Nursing Innovation Studio (https://nursing.osu.edu/offices-and-initiatives/office-innovation-and-strategic-partnerships/innovationstudio) and Northeastern Healthcare Innovation & EntrepreNURSEship (https://nuhealthcareinnovation.com/).

In Australia, Swinburne University of Technology has established a Master of Entrepreneurship and Innovation degree. The program focuses on the specific needs of entrepreneurs and innovators who want to successfully commercialize their innovation. It is tailored for those who want to bring visionary attitudes and possibilities to existing business ventures or non-business ventures (www.swinburne.edu.au 2011).

What about all the nurses not in a formal nursing program? Our experience has shown that nurses do not lack creativity or ideas for a nursing business. Nurses start out with a passion for helping others and desire to make a difference in quality of life. Yet, nurses rate themselves as low on having the actual skill set of a business owner. What nurses need are principles of business development, resources, and mentors. Nurses need technical support to take their idea from dream to reality. To fill this knowledge gap in our own state, we developed a nurse entrepreneur course, a blend of on-site and online instruction, which helps nurses move along on the path to business ownership.

We identified **four steps** to support nurses taking ideas and passion into business.

22.4.1 Transform Passion into Vision

"What the mind can conceive and believe, it can achieve." Napoleon Hill (1937).

Take a moment to dream about your ideal clinical practice. Write out your vision-what does your company look like? What is your mission? Why does your business exist? What do you value? Why do consumers need you in the marketplace? In our nurse entrepreneur course, we have participants create a vision board with photos and words that capture the essence of the vision. Images speak to the mind more powerfully than words, as they capture the feeling for the project. Passion is the driving force that provides the energy to persist through the challenges in starting a business.

22.4.2 Make a Plan

Develop a framework for your business. Yes, you absolutely need a business plan! But do not get hung up on this step. Writing a business plan, though necessary, need not be arduous. You have to think broadly about elements that go into opening a business. The basic components of a business plan are displayed in Fig. 22.1. (Flanagon, 1993).

The good news is there are plenty of free tools available—and people too! In West Virginia, USA, we partnered with our state-wide small business development office as we created our nurse entrepreneur course. We use a business canvas tool (Fig. 22.2) to help our budding nurse entrepreneurs work through the steps of writing their business plan.

Each participant works through several modules that are designed to be adapted to any variety of small business. For our US readers, free resources like the Small Business Administration's Small Business Development Centers (SBDC) are available in every state to provide tools and coaches who can assist with this process.

Components of a Business Plan

*Overview of industry involved, including current trends and issues;
- Details of target markets, pricing structure, promotion and advertising;
- Comprehensive description of the product or service, uses and features;
- Identified competition and comparison with proposed product or service;
- Description of operations, facilities needed, equipment and personnel;
- Description of management skills and resources available to the business;
- Identification of potential risks and how they might be managed;
- Time frame for implementation of various stages of business; and
- Financial plan including how much money is needed and a repayment schedule for money that may have been borrowed.

(Flanagan, 1993)

Fig. 22.1 Elements of a business plan

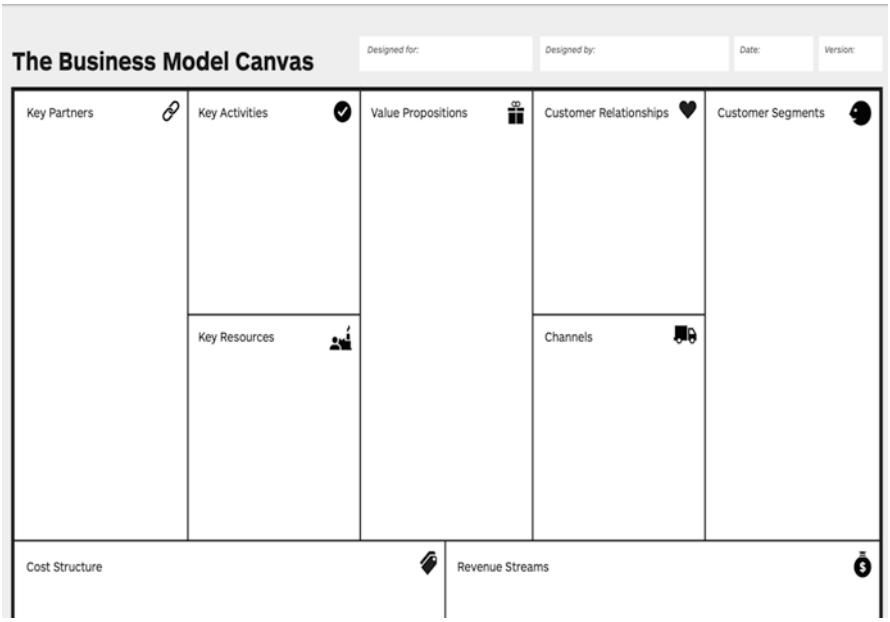

Fig. 22.2 Business model canvas (free download from Strategyzer.com) https://assets.strategyzer.com/assets/resources/the-business-model-canvas.pdf

Your business plan will include a market scan to help understand what your consumers want, a SWOT analysis to identify opportunities and obstacles to your business idea, and legal considerations. You will need to decide what business structure is best for you. It is important to find a balance between your passion and skill set and what the consumer wants and for which he/she is willing to pay. Above all, if you are low on resources, the best place to spend your money as a new business owner is on legal support. Incorporating a business and creating a sustainable structure is critical to long term success. If you are new to this area, we urge you to think twice about doing this part on your own.

How do you know what your consumer needs? Every successful business meets a need and fills a gap in the marketplace. Identifying the gaps and needs and creating a service or product to fill that need is the foundation for developing and marketing the business. Being aware of the direction of trends in healthcare is a good start. Riding the wave of change in the direction of change supports momentum for business success. Back these observations up with data that identifies the area with the biggest need, desire, and ability to pay for the product or service being provided.

At the end of this chapter, a resource list is provided to help you to identify population health trends. You might also conduct polls or focus groups to further identify and personalize the dynamics and specifics regarding what people are seeking and willing to purchase. These processes also help to shape the message from nursing jargon to language with which the public identifies for marketing.

Business models vary. Many APRNs think about owning their own clinical practice, starting out as a solo practitioner, maybe growing over time to a group practice. Maybe a brick and mortar practice does not appeal to you but you can consider opening a house calls practice or offer tele-health services from your home. Take your show on the road, contract with small employers to provide on-site primary care at certain intervals, augmented by tele-health visits. You really can and should be creative to meet the needs of your consumers while engaging your passion.

Expand your thinking on how people will pay for your care. Perhaps your services are not typically covered by traditional insurance or national health service. That does not mean you cannot or should not open your business—it just means you need to figure out demand and for what people are willing to pay. Perhaps your business can contract with the ministries of health, expanding their slate of services. Trust us when we say that you do not have to rely on health insurance to open a business—but you do have to rely on excellent market analysis, provide a product or service that is needed and price it attractively enough that people will pay cash for it.

Today, health insurance is pretty costly, with high co-pays and deductibles. It can be helpful to think of consumers as mostly cash pay when they have to meet very high deductibles before insurance coverage begins. Can you offer affordable primary care for less than the deductible? With an emphasis on health promotion and wellness, nurses are perfectly positioned to provide these services.

22.4.3 Find Startup Money

Financing and projecting profits is critical. For anything we do, we need to know if it is sustainable, how long will it take for us to cover our costs and make a profit and most importantly who is going to pay for it. It is not a bad thing to make money, in fact your business depends on it! Therefore, financial planning is critical. It is important to know how many clients, hours, or products must be sold to break even and be profitable.

Thinking about finances can be as simple as comparing it to how you manage your personal wealth, or as complex as creating a projection that drives a company 5 years into the future. Either way, one has to have a basic understanding of profit margins, loss, checks and balances, and assets. Cash flow is king, so any business you create will be laser focused on cash flow. You do not need to be an accountant or finance expert to participate in these conversations, but you do need to have a general overview of these terms and understand the driving factors. You may need to read some articles, take a class, or listen in on seminars. It may also be a good idea to get a finance mentor, or trusted friend who is really good at these things and connect with them early and often.

Startup costs for a business vary and depend on what type of goods and services you plan to offer. The more planning you do, the more refined your slate of services is, the more you can figure out what it will cost to open your business. This preplanning is also critical to knowing what type of goods and services you need (quantity wise) to sustain the business over the years ahead.

Startup funding can come from multiple sources, including personal savings, bank loans or independent funding organizations or angel investors who may be interested in supporting your idea. Foundations are an excellent source of funding for not for profit businesses that are serving the needs in a local population. Foundations range from large national foundations and government grants to small community and family foundations. A local nonprofit association is a great resource for locating sources in each community. Here again your local SBDC will be a source of information on funders and can help you shape the proposal for success.

22.4.4 Build a Network

Opening a new business is exciting, exhilarating, and a lot of work! Do not go it alone. While this may be your first business, others have gone before you. Getting feedback and input is important. In addition to coaches, creating a small mastermind group of people who are working toward similar goals can be a source of inspiration, creativity, and support as the business starts to take shape. Finding a mentor who can share insights and support is another excellent resource. Every new venture has ups and downs. The wisdom of an experienced entrepreneur can support you to persevere in challenging times.

22.5 Journey to Entrepreneurship

Entrepreneurs do not wake up one morning and say, I am an entrepreneur. Embracing an entrepreneurial mindset is a process. It happens as part of a journey. Your years of practice or age do not have anything to do with how you progress through this journey. What does work is your ability to practice self-awareness.

Take time for personal reflection to recognize your strengths and weakness, see challenges from a different perspective, and then create innovative and value-driven solutions that fill the need you see. For some entrepreneurs, this process happens rather quickly after embarking on a career, maybe because resources are available or opportunities are presented. For others this journey takes some time. Many entrepreneurs spend years understanding and studying a need before they ever begin to think about creating comprehensive solutions to address it.

The journey is personal. One can be trained in aspects of entrepreneurship, yet the process of becoming an entrepreneur is just as individual as becoming a leader. What we have learned over the course of our collective careers is that one of the most critical steps to nurturing an entrepreneurial mindset is self-awareness and deep respect for this process.

Self-awareness is the ability to look within to understand and accept your strengths and weaknesses so you can build upon your strengths, and create teams that fill your weaknesses. Without deep personal reflection, you risk the potential of missing something big or going into something headfirst that would never work because you have blind spots. Personal growth is paramount to long-term

sustainability and success. Just as leadership requires personal time and attention for growth, entrepreneurs need to give themselves time to develop and identify the best ways in which to use their gifts to impact the greater good.

Nurture your creativity. Recognize that you have a creative spirit. Then honor and develop that creativity through doing things that fuel your soul. For example, you may like to build things, or work with your hands, so roll up your sleeves and do something that excites you and sparks that inner creativity. You may enjoy learning and decide to study something in an entirely different area, maybe change your scenery for a few days while working, or even take a few minutes out of your morning to vision how you want to use your creative bones in your current practice. Maybe you paint with your patients, or sing with them. Whatever it is, just do it and you will notice over time that your creative juices start flowing!

I am a Nurse combined with I am a Nurse Entrepreneur gives you permission to change the world. The world is waiting for you to own your truth, so do not hold back, take that first step on your journey today!

22.5.1 Taura's Journey

I never imagined I would be a business owner; it was never a part of my plan. As a young nurse, I was not exposed to the possibilities of nursing outside of academia and practice. I was often encouraged to avoid the business conversation. Fortunately, I was blessed with very progressive nurse mentors, healthcare mentors, and coaches who helped me shift the way I thought about my work.

I stepped into entrepreneurship when an opportunity arose that I could not resist.

Valtari Bio Inc. (http://valtaribio.com) was launched in 2015 as a result of my nursing passion and practice to improve stroke care and ability to step outside my comfort zone. As a young trauma nurse, I was intrigued by the possibility of leveraging the immune system to better understand stroke and provide patients and their families more information regarding their ability to recover. I became a nurse scientist and began the arduous task of studying the immune system in stroke patients. After 10 years of research, I found that not only could we use patterns in the immune system to aid in stroke diagnosis, we may even be able to use the immune system to stratify treatment and help patients recover more fully. I remember the day clearly when I said yes to taking all of that knowledge out of academia into the marketplace! A colleague saw tremendous value in the intellectual property I created and half-jokingly suggested we start a company.

The journey has changed since we launched. The experience enlightened me to think beyond what I thought possible for my career. Not long after creating Valtari Bio, I launched Deep Roots Healing LLC (http://www.deeprootshealing.org/) which is based on an innovative model combining health and wellness with leadership and career coaching for those who have experienced significant heath crises. And Deep Roots Healing is not the last of my business ventures! Once I took the first scary step, the next step was a little easier. Opportunities presented themselves and I was transformed in the process. What drives me is the real promise of making

an impact at the level of the individual patient. I am a nurse whose clinical experiences drive innovation. This simple statement has made a difference when talking to clients, investors, collaborators, and strategic partners.

22.5.2 Aila's Journey

I was a breech birth. I think this set my course in life. Often I find myself in a non-traditional situation, and then I have to figure out what to do with it. When an Occupational Alcoholism Program grant I was working under ran out in 1974, one of the businesses for which I was consulting decided they wanted to continue the relationship and offered to pay me as a consultant. I had a customer before I had a business. At that point I consulted an attorney friend who recommended that what I needed was an accountant. The accountant instructed me to register the business with the Secretary of State for a nominal cost, open a checking account, deposit the consulting check, and purchase supplies from the checkbook. Instantly, I was in business. That business evolved into what is known as an Employee Assistance Program today. I developed contracts with many employers, trained supervisors and did employee seminars, which took off into a national public speaking part of the business. That led to developing books, tapes, and CD programs sold back of the room and online.

To the assessment and referral part of the EAP I added a coaching certification, evolving into a health coaching service. *LifeQuest International, LLC (ailaspeaks.com)* continues to evolve, grow, and change. I have been a sole proprietor, created and dissolved two partnerships and contracted with other professionals and a non-profit coalition. I have had a large office with employees and now work virtually from home. The journey has been challenging and extremely rewarding. Coaching new entrepreneurs, especially nurses is one of the highlights of my business today!

22.5.3 Anna's Journey

Meet Anna Sort, an entrepreneur from Spain. Anna Sort is a nurse who has found her passion as a digital health pioneer, nurse entrepreneur, inventor, professor, author, and public speaker. Follow Anna on Twitter at Anna Sort @ Lost Nurse. Here is her story:

> "I am a nurse and a gamer and I am here to make health fun."

And so the interview begins, telling Anna's story of how she came to be an entrepreneur. Recognizing the important role that nurses have as educators in health promotion and prevention, she also observed that traditional approach of teaching, sitting with the patient, covering important concepts, and closing with a take home pamphlet just seemed to fall short.

"We need to make a way for newer technologies, to help people get and stay addicted to health." Thus, she created PlayBenefit, a digital technology company

designed to better connect the individual patient, with his or her care needs through behavior change and feedback about the change- and have fun doing it! Engaging apps, merge concepts from video games with health and wellness activities to get people to move more, (also called exercise), eat for better health, to take medications as prescribed, and to gain disease control.

Anna offers three tips for beginning nurse entrepreneurs:

1. *The problem isn't the problem, it's your attitude about the problem*
   We tend to make things bigger than they are, taking them out of scope. Keeping this tip in mind helped me take a step back and rationalize the problem objectively. Helps you to see where you are going, the resources and strategy needed, and not see it all from your own personal perspective.
2. ***Deal with frustration***
   I cannot empathize how important this is. What is frustration? Frustration appears when your team, your provider, your whatever, is not meeting your expectations. This might be for several reasons, but most likely, it is because they are not aligned with you. To prevent this, always, always, communicate your vision, a "why," and a validation: "We are going to climb the mountain BECAUSE we need the resources that are only available on the top AND we will know we climbed the mountain because we will put a flag on top."
3. **Delegate the right way**
   I read everywhere that it is important to delegate. In my experience, it is not about knowing what to delegate (that is the easy part at least for me now), what I am learning now is HOW to delegate. This is very related to point number 2 and can cause, besides frustration, mistrust with your workers. To prevent this, have meetings where you let everyone know the minutes (what you will discuss), provide the vision, discuss the methodology and the "why," provide validation, and write it down for the others and send it by e-mail after.

22.6 Recommendations to Support Entrepreneurship in Nurses

We close this chapter with specific recommendation for various sectors in nursing.

22.6.1 For Individual Nurses

- Embrace and nurture an entrepreneurial mindset, maybe through hiring a personal coach or seeking out learning opportunities.
- Align daily schedule with life and career goals.
- Support and develop holistic, transcendental, and entrepreneurial leadership.
- Use career planning, training, and education resources.
- Creatively leverage existing resources.

- Tap into Alumni for mentoring and funding opportunities.
- Seek public and private partnerships for financial support.
- Partner with local clinicians to identify innovations.
- Seek funding beyond traditional grants/contracts.

22.6.2 For Nurse Educators

- Incorporate the processes of innovation, entrepreneurial concepts, and mindset into nursing curricula at all levels of nursing.
- Create fellowships, training programs, and mentoring networks to train/mentor nurse entrepreneurs and encourage students to seek out opportunities to build their innovations, like the Johnson & Johnson Nurse Innovation Fellowship https://nursing.jnj.com/innovate-with-us/nurse-fellowship
- Select nurse entrepreneurs as preceptors for APRN students.

22.6.3 For Governments and Healthcare Delivery Systems

- Support policy reform that reduces scope of practice barriers for all nurses.
- Implement reimbursement mechanisms that pay nurses directly for care.
- Create a culture of innovation, incentives to support nurse entrepreneurship.
- Develop mechanisms to track nurse-led innovations, businesses, and companies.

22.7 Links to Resources for Nurse Entrepreneurs

NurseMakers http://makernurse.com/.

International Council of Nurses (2012). Handbook on Entrepreneurial Practice. https://www.icn.ch/sites/default/files/inline-files/2012_Handbook_entrepreneurial_practice_eng.pdf.

SONSIEL: Society of Nurse Scientists, Innovators, Entrepreneurs and Leaders https://www.sonsiel.com/.

Small Business Development Centers (http://www.sba.gov/sbdc/).

National Nurses in Business Association (https://nnbanow.com/).

National Nurse Practitioner Entrepreneur Network (https://www.nnpen.org/).

County Health Rankings & Roadmaps (https://www.rwjf.org/en/how-we-work/grants-explorer/featured-programs/county-health-ranking-roadmap.html).

Business Canvas Model. https://www.strategyzer.com/ Excellent resource for business planning.

Aspen Institute Health Innovators Fellowship https://www.aspeninstitute.org/programs/health-innovators-fellowship/.

American Academy of Nurse Entrepreneurs https://aane.us/.

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Advocacy for Nurses and Consumers

23

Andrea Brassard, Winifred V. Quinn, Patrice Little, and Toni DiChiacchio

With their background as registered nurses, nurse practitioners (NPs) and other advanced practice nurses (APNs) have the training and experience to advocate for individual patients and families to get the healthcare services they need. Advanced practice nurses and their supporters also need to advocate more broadly for legislative and regulatory changes to eliminate barriers that limit the care APNs are allowed to provide. This chapter discusses advocacy for advanced practice nursing and for patients and describes strategies to change restrictive laws in the United States with suggestions for global advocacy.

In the United States, advocacy is an essential element of graduate education as outlined by the American Association of Colleges of Nursing. Advanced practice nurses are prepared to advocate for the profession of nursing and for the health of the public (The Essentials of Master's Education in Nursing 2011). Advanced practice nurses are taught how health policy works on the local, state, and national levels. With this knowledge, advanced practice nurses can position the nursing profession to bring about change that leads to healthy outcomes.

In the United States, advanced practice nursing roles, like all clinical sectors, are primarily regulated at the state level. Because advanced practice nurses diagnose and prescribe, early legislation was carved out of state medical practice acts to require physician oversight, particularly for prescribing. As the number of APNs

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increased and consumers gained access to APN care, APNs sought to practice without contracting with medical doctors.

Many policymakers, or legislators, who regulate government funding, administer governmental programs, and license various practices including nursing, are unfamiliar with the advanced practice nursing role and their contributions to health outcomes. This is especially true in some countries that have recently implemented the APN role. Consequently, legislation to modernize APN practice can stall, delaying movement toward increasing access to care.

23.1 Advocacy Exemplar: Winning Strategies

The *Center to Champion Nursing in America* (CCNA), the operational arm of the Future of Nursing: *Campaign for Action,* both initiatives of AARP Foundation, AARP and the Robert Wood Johnson Foundation (see Chap. 4), envision an America where everyone can live a healthier life, supported by nurses as essential partners in providing care and promoting health equity and well-being. The first recommendation of the 2010 landmark report *The Future of Nursing: Leading Change, Advancing Health (*Institute of Medicine 2011*)* is to modernize all state and federal APN laws. In other words, states should remove all legal barriers that prevent APNs from providing care to the full extent of their education and training. Furthermore, the federal government should remove the barriers they place on APNs' ability to provide healthcare.

About the same time as this evidence-based recommendation was announced, AARP, with 38 million members, the largest consumer organization in America, prioritized APN-related policies for AARP advocacy teams. Over the past decade, AARP has been involved in successful legislation in at least 22 states (Quinn 2019) as well as some involvement in nursing policy at the federal level.

In 2017–2018, CCNA and the American Association of Nurse Practitioners (AANP) convened nursing leaders and AARP state office representatives to share "winning strategies" at three regional meetings. Attendees heard from organizations that have participated in successful full practice authority campaigns, developed strategies and actions for aligning nursing's goals with those of legislators, learned about building coalitions that get attention and results, and practiced identifying best messengers to take up the cause with audiences they hope to persuade.

One of the lessons learned from the "winning strategies" convening is that state legislators view the scope of practice issue as a fight between nurses and physicians, and they do not want to mediate. Several states have postponed legislation until nurses and physicians agree on principles. Nurses negotiating with physicians are overpowered at an "uneven table" (Krek 2002) and rarely are able to successfully negotiate full practice authority. We learned that when communicating with legislators, APNs were spending their time talking about why the laws were bad for them, not emphasizing how modernizing the laws would help patients and family caregivers, and provide more access to care for all. We urged APNs in the training to solicit

the interests of consumers as constituents who benefit from APN care and tell stories about patients whose care was delayed because of regulatory barriers (Quinn 2019).

Another lesson taught was how to identify the best messenger. In some states, the same few nurses have met for years with the same legislators on this issue, using the same tired message focused on what APNs need. These pioneer nurses deserve thanks and praise. However, it may be time to change the messenger as well as the message (Quinn 2019). Ideally, the messenger should share similar political ideology party and live in the legislator's district.

We have seen stark difference between how physicians and nurses engage with policymakers. The former often donate to political campaigns, host fundraising events, or run for office. The latter have rarely participated in these activities. Perhaps nurses would want to reconsider these strategies.

23.2 Social Media

Messages should be conveyed through in person meetings, phone calls, emails, and social media. Social media can go a long way toward raising awareness about an issue. Social media can help generate support, drive people to action and communicate directly with influencers (Boyle 2018). Many social media platforms are out there, including Facebook, YouTube, Twitter, Google+, Pinterest, Snapchat, Instagram, and LinkedIn. When it comes to using social media for advocacy, Twitter and Facebook dominate. Nearly 75% of advocacy organizations use Twitter for their advocacy work and nearly 70% use Facebook (Rehr 2017).

Suggestions for using social media include:

- Clearly identify your goal and the audience you want to reach when using social media.
- Craft messages that the world can understand. Do not use jargon.
- Make your message high level and understandable by all people, not just nurses or those in healthcare.
- Mention other organizations in your coalition using their Twitter handle so they will engage in the conversation or retweet you.
- Consider "tagging" lawmakers directly. Use this tactic judiciously (Boyle 2018).

The Future of Nursing: *Campaign for Action* also encourages nurses to reach out to organizations beyond nursing as allies in this effort to modernize scope laws. Other health organizations, particularly those that employ APNs, can be helpful in legislative efforts. Remember that businesses and industry are also impacted by regulatory barriers. The requirement in many US states for contracts with physicians comes with costs, which can be passed on to the consumer. Learn from the United States that requiring physician oversight in legislation sounds collaborative but prevents APN autonomy, thereby reducing patients' access to care.

Do's and Don'ts of what to say when talking to policymakers about access to APN care

DO	DON'T
Say **nurse practitioner**—and all advanced practice nurses (APNs)	Don't say **doctor or physician**
Say a **clinician shortage** is hitting the state (or region or country) hard	Don't say APNs can take the place of physicians
Say **modernize** nurse scope of practice	Don't say **expand** nurse scope of practice
Focus on how **patients** are affected **first**	Don't focus on how **nurses** are affected **first**
Use statements backed up by **fact**	Don't use statements without **credible sources**
Focus on people/patients. How do these laws, regulations, and policy affect people?	Don't make it about physicians/doctors versus nurses

23.3 Advocacy on a Global Level

Advocacy in nursing has evolved from highlighting the powerlessness of patients to promoting the expansion of APN roles. Although research is limited on how APNs function as advocates in the USA and other countries, the same principles used to advocate for a patient's health and behavior can be applied to promote change in governance. As APNs increase in the United States and internationally, use community engagement to change regulatory practices. APNs can initiate advocacy for many reasons, and the most common form of advocacy illustrated in the literature is being a voice for patients (Hanks et al. 2019).

The role of APNs in advocacy is supported globally through organizations such as Sigma Theta Tau International and the International Council of Nurses. Countries with universal healthcare are challenged to engage in public policy to expand the APN role. Specifically, international nurses are encouraged to increase visibility, awareness and understanding of the APRN role, and its impact on the health and well-being of consumers (Ryder et al. 2019). Nurse educators who are establishing advanced practice nursing programs at the graduate level globally should lead in advocating for APN roles in practice and regulation and support research in this area (Ryder et al. 2019). Focus advocacy efforts on how APN practice can improve the health of the population. The *Nursing Now!* Campaign can be the impetus for advancing APN practice and care globally (Benton et al. 2019).

Country-specific regulations underpin APN practice, including the right to diagnose and the authority to prescribe medication and treatment (Definition and Characteristics of the Role n.d.). APN titles differ from country to country, but it is important that official titles be recognized for nurses working in advanced practice roles (Kaplan 2018). Titles say who APNs are and differentiate APNs from other nursing levels (Scope of Practice, Standards and Competencies of the Advanced Practice Nurse 2005). Title protection also protects consumers from imposters who do not have APN education and training (Institute of Medicine 2011). In addition to title protection, nurses can advocate for International Council of Nurses (ICN) standards for regulation including nationally recognized credentials and regulations that

protect the public as well as the APN (The Discipline of Advanced Practice Nursing—ICN Guidelines 2018). In the United States, APN regulations were patterned after medical practice acts. International APNs should avoid this regulatory quagmire and seek regulations as their own licensed sector providers.

APNs are not replicating the medical model (Benton 2019). APNs are experienced and highly educated registered nurses who manage the complete clinical care of their patients (Institute of Medicine 2011). Advanced education and training builds on holistic patient care. APNs possess complementary curative and preventative skill sets (Bryant-Lukosius et al. 2017), essential for improving healthcare globally.

All APNs should take an active role in removing barriers to practice to increase access to high-quality, cost-effective care. Ideally, APNs are encouraged to advocate for the APN profession from when they enter APN educational programs. Policy barriers are apparent at the practice, health system, state, and federal levels. Individual APNs working in coalitions with consumers, businesses, and organizations can use political strategy and tactics to lead change and advance health. In her keynote address to the tenth ICN NP/APN conference, ICN President Annette Kennedy said, "If we are not invited to the ... decision table with the key players, we must bring our own chair, sit at the table [and] participate." (NP/APN Network Bulletin 2018; Krek 2002).

Keep in mind that advocacy itself is empowering (Wohlever 2019). Advocacy expands your network and your community (Wohlever 2019). Advocacy introduces you to other dedicated and caring APNs and APN advocates. Get involved. Be invited to policy tables. Stand up and speak up for patients and nursing, and make a difference.

23.4 Case Study: Georgia APNs Join Forces to Speak with One Voice

Patrice Faye Little, DNP, FNP-C

This case study describes an APN's quality improvement project that focused on the unification of APNs' voices as a step to increase the access to care in Georgia. This case study demonstrates the steps to collaborate and the approach to voice concerns to policymakers.

The state of Georgia in the United States ranks as one of the lowest states in healthcare outcomes. Specifically, access to care is a challenge in rural areas and among underserved populations. Mainly, there are not enough primary care physicians to serve as a "source of care" for Georgians to access comprehensive services such as screenings and management of acute and chronic illnesses (Xue et al. 2016). Consequently, the use of the emergency department (ED) and hospitalizations continues to increase for conditions that APNs could appropriately manage (Kung and Lugo 2015).

Georgia is also one of 12 states in the United States with a restrictive practice environment (American Association of Nurse Practitioners [Internet] 2018). Georgia requires APNs to have a written statement that defines the joint practice of the APN and the physician on record with the Georgia Medical Composite Board (Stephens 2015; Regulation of Protocol Use by Advanced Practice Registered Nurses, P.L. No 410-11 § Stat. 43-34-26.3 [statute on the Internet] n.d.). Most policymakers who regulate nursing practice do not fully understand how the contracts with physicians pose a barrier to APN care (Villegas and Allen 2012). Most policymakers rely on physicians for expert health information. In Georgia, as in other states, the medical organizations of Georgia expressed unfounded concerns regarding the sufficiency of education and training of APNs to have full practice authority (Brooten et al. 2012; Donelan et al. 2013). This growing concern presented as an opportunity for APNs, as consumer advocates, to clarify the quality and safety of APN education and training to policymakers in order to increase access care to Georgians.

As the project leader, the APN conducted a needs assessment, which identified that the organizations representing the four APN groups (Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNM), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS)) functioned independently in the pursuance of APN practice change to meet the healthcare needs of Georgians. The assessment also revealed that Georgia APNs have not collectively had an active role in healthcare policy since 2006 when APNs were granted prescriptive authority.

Previous studies have shown that unification among advanced practice organizations has been a successful approach to working with the legislature to remove restrictive practice laws. Engaging in health policy is the "social and ethical responsibility" of regional and national nursing organizations, as well as healthcare stakeholders (Ellenbecker et al. 2017). The power of unification has been demonstrated in states that modernized legislation.

The APN's doctoral project began with a roundtable discussion of the impact current restrictive laws have on access to care for Georgians. The first discussion was among Georgia APN leaders and key stakeholders who developed a cohesive list of practice barriers that prevent APNs from providing comprehensive primary care in rural areas and among underserved communities. The APN then met with selected policymakers. Practice barriers were grouped into six themes illustrated in the below table.

Although legislation to remove the required physician contract in Georgia was not successful, the responses from the APN and stakeholders' dialogue suggest how APNs could frame their messages to policymakers. Consistent messages from all APN groups are important. Fostering relationships with policymakers as well as other influential groups is encouraged. The evidence strongly supports APNs connection with outside organizations to strengthen their message. The future of primary care in Georgia is dependent on the collaboration of APN organizations and their champions.

Themes abstracted from APN and stakeholders roundtable discussion

Themes	APN/stakeholder exchange responses
Theme 1: Challenges with unification of APN groups	"When you are in a small town...and you're starting your own business, you don't have a lot of time to attend meetings. Many of [the meetings] are regional." (APN) "I think our biggest barrier in Georgia on the APN side is complacency and fragmentation amongst ourselves, and we still have to [overcome] those hurdles and maybe…find some ways to strategize and bring more nursing unity and trust in the state." (APN)
Theme 2: Accessibility of physicians and cost of collaborative agreements	"So [Community Service Board] have these APNs that they would love to start, but they're having to go out and try to recruit physicians to be that collaborating physician, and the state law has a requirement that a physician can only have four APNs or a combination of APNs and Physician Assistants." (APN) "When I was a former Director of Student Health services, we paid a [collaborative] physician to sign off on 10% of charts. It is a waste of money because there is no value added. This is a huge burden to innovation of APN practices. It is illegal to hire physicians...the financial piece is big problem with the current arrangement." (APN)
Theme 3: Challenges with referrals initiated by APNs	"Consultants are hesitant to deal directly with the nurse practitioner, and they prefer that you use your collaborating physician as an arm for making the referral [instead of] getting [APNs] involved." (APN)
Theme 4: Visibility of APNs	"So, for now, you just [have to] use what we have (the data)." (stakeholder) "If we could identify ourselves as the primary billing source, then the numbers would be easily available…but if there was just some understanding about how many nurse practitioners that were in the state of Georgia, I think that impact would be incredible on legislators." (APN)
Theme 5: Healthcare consumer issues	"I think the very first thing we should say, before we (APNs) talk about our issues, and theirs (physicians), this is about Georgians not having access to care." (APN) "We [APNs] want to improve the rural health crisis in Georgia." (APN)
Theme 6: Engagement & recruitment in the legislative process	"I was wondering if there are any stories that people could get from collaborating physicians that would dare to say, 'This system does not work. It's inefficient. It's busy work; It's a waste of my time.' That would be powerful." (stakeholder) "I think we need to find ways to tap back into more seasoned providers...also tapping into our new energy of these students that are willing (to get involved)." (APN)

23.5 Case Study: Legislative Victory in West Virginia

Toni DiChiacchio, DNP, APN, FNP-BC, FAANP

In September 2012, I testified for the first time to the West Virginia (WV) legislature about regulatory impediments that were a threat to the sustainability of

providing my community access to the primary care I delivered in the new practice I had opened. As a nurse practitioner with an entrepreneurial spirit and a motivation to care for those most in need, I had seen an opportunity in my state amidst two significant events in 2010: the online release of *The Future of Nursing: Leading Change, Advancing Health (*Institute of Medicine 2011*)* and the passage of the Patient Protection and Affordable Care Act (PPACA). The former was an affirmation, by none other than the Institute of Medicine, that Advanced Practice Nurses (APNs) were valuable members of the healthcare system and competent to deliver care without unnecessary regulatory contracts for oversight from other professionals; the latter was anticipated to significantly increase the Medicaid population in my wild, wonderful and economically challenged state. It was the ideal time to prepare to open a primary care practice focused on the care of the marginalized with chronic disease. Through the process of developing my business plan not only did I discover that many physician primary care practices limited the number of Medicaid patients they could take, but 40% of the patients that visited the Emergency Department of our local community hospital were without a primary care provider. The picture was clear that there was a demand for care that was going to grow. The one challenge was that West Virginia required a collaborative agreement with a physician in order for a nurse practitioner to prescribe medication. Undeterred, over many months, I diligently searched and ultimately found, a physician willing to fill that role until in short order that unnecessary law would be retired—at least that's what I thought as I shared my concerns with the legislators on that September day in 2012. I would learn that change, regardless of how logical it appears, is not necessarily as easy to compel as expected.

23.6 History of APN Regulation in WV

APNs have been formally recognized in West Virginia law since the early 1990s. Initially it was merely an "announcement" of advanced practice but changed to a formal APN license in 2013. As previously mentioned NPs were able to *practice* autonomously but were required to have a physician "collaborator" to *prescribe*. This same policy applied to clinical nurse specialists (CNS). Certified nurse midwives (CNMs) and certified registered nurse anesthetists (CRNAs) were not permitted to practice in their roles unless they had a formal physician relationship for oversight. Over time, some limited incremental changes were made related to specific drugs that APNs were permitted to prescribe, such as removing the prior exclusion of prescribing anticoagulants, but others remained. APNs were not allowed to prescribe the most dangerous category of opioids, and benzodiazepine prescriptions were limited to a 72-h supply. The physician oversight requirements in collaborative agreements remained, were vague, and physicians were not required to be on-sight when the APN prescribed. Bills to remove all these limitations and permit full practice authority (FPA) were regularly introduced starting in the late 1990s.

In 2012, the state legislature passed a new "sunrise application" process that could be utilized by professionals to request the legislature to formally examine and

address requests for changes in scope of practice regulations. An application to invoke this process was submitted by the West Virginia Nurses Association (WVNA) in 2013. The application was over 100 pages and asked the legislature to remove all barriers that limited APNs from practicing to the extent of their education and training. The response to the request was met with a positive analysis as to APNs' competence, efficacy, and cost-effectiveness; however, ironically, the recommendations were for the legislature to require physician oversight for prescribing for 5 years and more disturbingly recommended that APNs be regulated by a different profession—the Board of Medicine (West Virginia Legislative Auditor 2014). The WVNA refuted the recommendations and pointed out the discordance between the analysis demonstrating safety and efficacy of APN practice, with the recommended need to be regulated by a separate profession.

23.7 Power Shift Creates New Opportunities

In 2014, a historic transfer of power occurred in the West Virginia legislature. After more than eight decades, the Republican Party took control and thus new committee leadership was named. While the former Health Committee chairs opposed FPA, having new leaders in those roles increased the probability of a FPA bill being placed on committee agendas, which had never previously been allowed. It also opened opportunities for coalition building with powerful stakeholders who had noted the futility of working on the issue when previous legislative leaders had expressed opposition. While these groups may have conceptually agreed with the premise of APN FPA, it had been seen as unwise to commit efforts to advance the issue when it was unlikely to gain traction.

New Republican legislator "champions" were quickly identified to sponsors FPA bills in each chamber including Delegate Amy Summers (R-49), a registered nurse elected in 2014. The FPA talking points were adjusted to appeal to Republican ideology, focusing on the detrimental effect of excessive occupational regulation on employment, economic development, and compliance costs. Consumer choice was also highlighted. The strong body of evidence showing the competence and quality of care provided by APNs was widely disseminated with all policymakers with particular emphasis on educating new members of the legislature.

The WVNA promptly sought additional coalition partners, sharing how amending the law would provide wide benefit. A number of organizations had been longtime supporters of FPA including Our Future, Our Children Campaign, West Virginians for Affordable Healthcare, and the West Virginia Budget & Policy Center. Focus was placed on the coalition of supporters as to volume but also diversification of political perspectives and philosophies. The Future of Nursing West Virginia (FONWV), chartered by the WVNA, the West Virginia Hospital Association (WVHA), and the West Virginia Organization of Nurse Executives (WVONE), is the state action coalition associated with the national *Campaign for Action.* The FONWV is charged with implementation of the Future of Nursing recommendations in the state and has many influential individuals serving as strategic advisers.

AARP West Virginia, one such organization, has an exemplary reputation and powerfully advocates for consumers and their members. In preparation for the 2016 legislative session, AARP WV became a central and integral coalition partner. They brought not only their powerful reputation but also operational strength and most importantly, showed that FPA was not an attempt motivated by nursing self-interest, but would bring broad benefit to healthcare consumers and their caregivers.

23.8 Strategic Efforts

Strategic decisions formulated by the coalition team addressed what chamber to focus on initially, forecasting positions of each legislator, tactical matching of the appropriate individuals/groups that could most effectively influence undecided legislators, and the key evidence to present during legislative testimony.

Grassroots efforts were operationalized through briefing AARP volunteers on the issue so they could fully understand the impact, could share talking points with legislators and answer questions. Nurses in every senatorial district were identified by the WVNA and designated as nurse leaders to coordinate events with their local legislators prior to the beginning of the legislation session, particularly those that could be a swing vote. Their mission was to provide expansive education on the issue and address any concerns.

During the session, the evening prior to committee hearings where the FPA bill would be heard, dinners were sponsored for legislative committee members to educate them, in a relaxed environment, on the importance of the bill. Attendance at every dinner included AARP, the WVNA lobbyist, and me serving as the WVNA nurse content expert. Various other experts were present intermittently such as a past fellow from the conservative Heritage Foundation who presented her research related to the benefits of FPA, and a political science professor and health policy expert from WV who shared his work on the impact on the affordability and access FPA would provide consumers.

It was a purposeful strategy. At most points of legislator engagement, while I was always present as the nurse content expert, I was not the prime messenger. Rather, other coalition members would lead the conversations. Only when questions were asked that others could not answer, would I provide insight. This was done to demonstrate the issue as a patient-centered consumer benefit rather than a "nurse versus physician" turf battle. The same tactic carried over to media appearances.

A public hearing was held prior to the first committee meeting in which the bill was heard. Twenty-one individuals presented with 17 being in support of FPA including: AARP, the Federal Trade Commission (in form of a Policy Advocacy Letter, Federal Trade Commission (2016)), APN patients, a public health nurse, the Heritage Foundation Graduate Policy analyst, WV Citizens Action Group, the Social Workers Association, WV for Affordable Health Care, Americans for Prosperity, the Funeral Home Directors Association, the WV Budget & Policy Center, APNs who explained barriers to care provision caused by over-regulation, and APNs including me who had lost their independent practices, The four opponents who spoke represented only physician groups.

The media regularly covered the issue during the session. They particularly noted the broad range of bipartisan support the bill received. Legislators expressed excitement working on the issue because of its bipartisan nature in the midst of an otherwise very contentious session filled with political wedge issue. The newspaper from Charleston, the city that houses the state Capital, noted the breadth of support across the political spectrum (Hindman 2016). The article began:

> *"The West Virginia Citizens Action Group is a progressive organization that fights for things like environmental protection, consumer advocacy and reducing the influence of money in politics. Americans for Prosperity is a conservative group that fights for things like less environmental regulation, pro-business policies and lower taxes. Founded and largely funded by the Koch brothers, it is a veritable poster child for the role of money in politics.*
>
> *Safe to say, the two groups agree on little. But they both agree that highly trained nurses in West Virginia should have more power to treat patients and prescribe medication without a doctor's supervision."*

23.9 Compromise

The bill first passed the House of Delegates handily, but the Senate had more opposition. There were some procedural delays in the Senate that, while nerve-wracking, were never expected to result in defeat. While closing in to the final vote for the bill, the Senate Majority Leader requested the team meet with senators who were physicians to discuss possible negotiations. That meeting did not result in an agreed upon bill. The next morning, just prior to the scheduled Senate floor session and 2 days before the session would end, a last minute conversation with the senator physicians who had been opponents of the bill, the AARP state director and I resulted in terms agreeable to all of us. Concessions to FPA were agreed upon in order to remove the most significant barriers. The concessions included:

- A three-year transition to practice period wherein a collaborative agreement for APNs to prescribe would be in place with a physician (the original bill had 2 years and the collaborator could be an APN with 10 years experience).
- Signatory authority for death certificates would be permitted if specific training was completed.
- APNs would not be allowed to prescribe the most dangerous category of opioids.
- A Joint Advisory Council on Limited Prescriptive Authority (Council) was formed to advise the Board of Nursing with a composition of four physicians, six APNs, a pharmacist, a consumer, and a representative from a School of Public Health. The Council would have no disciplinary power but could examine barriers and issues related to APN prescribing that negatively impact consumer care and access.

The Senate passed the bill 34–0. The House approved the Senate version of the compromised bill along with other technical amendments in a vote of 91–5 with four not voting/absent. The bill crossed the finish line with 4 hours left in the session and was later signed by the Governor to become law in June 2016.

23.10 Conclusion

Removing statutory barriers for APNs is an important step but only one of many hurdles APNs continue to face across the country. Even with full practice authority, payment policies by health insurers are often challenging with some not contracting with APNs and others requiring a physician be in the practice to receive payment. Others limit paying APNs for certain services despite those services being within the APNs' professional scope of practice. Thus the work continues. In 2018, West Virginia went on to pass a law that was widely supported by legislators, preventing health insurance companies from requiring a collaborative agreement to provide APNs payment for their services.

The fact that West Virginia APNs remain unable to prescribe Schedule II controlled substances remains a challenge to patients who seek APNs as their provider of choice, particularly for children living in rural areas of the state who have been diagnosed with attention deficit disorder. West Virginia is now one of only three states that have a complete exclusion of APNs having any ability to prescribe these drugs. The sociopolitical environment related to the scourge West Virginia has faced with substance use disorder has made removing this barrier difficult; however, we continue to discuss it with our legislators and share patient stories of the negative impact this limitation has on access, cost, and efficiency of the healthcare system.

23.11 Final Recommendations

Valuable insights were learned throughout this process, which started nearly two decades ago. Some essential points for anyone considering advocating for policy change include:

- Decide what you must have changed and what you are absolutely unwilling to accept. Somewhere in the middle may be a compromise that would provide at least incremental policy change, which can be better than stagnation and serve as an improved starting point for future efforts. However, when doing this make sure all coalition partners agree as they may have somewhat different goals. Also reflect on the potential impact a compromise may have across the nation for others who may be working toward similar goals in other states.
- Try to reframe any issue that appears a "turf battle" between two groups to a broader, consumer-centered problem that requires change. This may require nurses to hand over some of the messaging and advocacy to other coalition partners, which can be a challenge for some. But remember, the ultimate goal should be making positive change that benefits patients and consumers and achieving the goal is more important than the face or leader of the change.
- Develop a strong grassroots model to pair every elected official with a constituent nurse or other coalition member whom they know and trust who can discuss the positive impact of the change you are seeking. It is the constituents at home

that the legislator is representing and cares most about so capitalize on that influence to secure votes for legislation.

- When a vote is upcoming, be strategic when "pulling the trigger" on mass nurse or coalition member communication with legislators. The message should be commonly themed and of noticeable volume and vigor. But be respectful of legislators' time. If it is a vote you know you have strongly secured, you do not necessarily need to inundate their email box or voicemails.
- Using the services of a respected lobbyist is vital, especially when dealing with contentious issues. Do an adequate search, and vet your applicants with members of the legislature and legislative staff you have relationships with in a bipartisan fashion. The ideal candidate would be well-known, trusted, experienced, and well-liked by both legislators and legislative staff.
- Frame the message to whom it is delivered. Know what is important to the legislator and their district and speak to how your recommendation will address problems they are seeking to solve.
- Have a content expert who is immersed in the evidence supporting your position and have them available to policymakers nearly continuously but not as the primary messenger for all meetings or discussions.
- Build a strong coalition, including consumer advocacy groups. Seek out a relationship with groups that have well established legislative influence.
- Be ready to work tirelessly. Members of the core coalition team were at the Capitol for many long days commonly being the first to arrive and last to leave. Our AARP coalition partner very aptly shared at the kick-off of the session, "they may beat us, but it won't be because they outwork us." Having partners with that commitment and determination by your side is priceless.

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NGOs and Global Leadership Development

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Sheila Davis and Melissa Ojemeni

24.1 Introduction

Nurses and midwives number approximately 20.7 million globally and can be found everywhere: remote clinics, hospitals, government agencies, and intergovernmental organizations (WHO 2016). They work in diverse roles from bedside clinicians, policy developers to organizational change leaders (WHO 2013). Yet in the health nongovernmental organization sector (NGO), nurses are often difficult to identify even though they are doing the majority of the work.

NGOs are nonprofit organizations that are independent of any government and are typically founded to address a social or political issue. A recent literature search on the topic of nurses and NGOs identified no literature available in four peer reviewed databases discussing nursing or the nursing profession. Consequently, this finding highlights the need for more in depth analysis on the role nursing and nursing leadership is playing in a sector that provides the bulk of health services in many communities around the world.

This chapter provides a case study of the organization, Partners in Health (PIH). Specifically, the organization's inception, the evolution of nursing within the organization and two examples of nursing and nursing leaders working to improve nursing practice at two of PIH's sites: Haiti and Liberia. These examples will provide tangible tips to inform nurses on the realities and characteristics needed to work in an international NGO.

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24.2 Background

PIH is an international nongovernmental organization located in ten countries globally providing health care to the most vulnerable. PIH partners with local and national governments, not creating parallel heath systems, but rather working to build and strengthen health systems according to the priorities of local communities. PIH has pioneered novel, community-based treatment strategies that demonstrate the delivery of high-quality health care in resource-poor settings. Currently PIH works in Haiti, Peru, Mexico, Rwanda, Malawi, Lesotho, Liberia, Sierra Leone, Kazakhstan, and in the Navajo Nation in the United States. The University of Global Health Equity (UGHE) located in Rwanda was started in 2015 by PIH to create a University that advances global health delivery by training a new generation of global health leaders who can both build and sustain effective and equitable health care systems.

The founders of PIH include Drs. Paul Farmer and Jim Kim, both Harvard Medical students at the time, Ophelia Dahl, a young volunteer from England working at a small eye clinic in the central plateau of Haiti, and Todd McCormack who was Dr. Farmer's roommate at Duke University and went on to have a successful career in business. PIH now has over 17,000 employees and works in partnership with Ministries of Health and local human resources for health to provide nearly four million people with primary care and eight million people with secondary and tertiary health care globally. The organization is considered one of the leaders in global health delivery. Based on the premise that health is a human right, the organization strives to bring the benefits of modern medicine to rural and marginalized communities. Since its inception, PIH is affiliated closely with Harvard Medical School and the Brigham and Women's Hospital in Boston and is known as the training site for an entire generation of global health clinicians.

Dr. Farmer is a prolific writer and authored hundreds of publications about global health. His work with the rural poor in Haiti was the subject of the book, *Mountains beyond Mountains* by Tracy Kidder published in 2003. This book describes the beginning of PIH and Dr. Farmer's work between Boston, Haiti, and Peru up until the year 2000. Also highlighted, is another founder, Dr. Jim Kim, who went on to work at World Health Organization and served as President of the World Bank from 2012 to 2019. Because the introduction to PIH for many is the book, *Mountains Beyond Mountains,* the role of the thousands of others who created and worked at PIH are less well-known. Since its inception, PIH has employed a large number of community health workers, nurses, and operations staff but the organization is best known through two of its physician founders.

24.3 Nursing and PIH

Nurses have always been strong contributors at PIH sites, but because there were not counterparts in the US office to collaborate with or to illuminate their work, their impact outside of individual sites was less known. Each PIH site is

autonomous and the leadership structure varies from site to site. The vast majority of current and past site executive directors are physicians and a Medical Director or Chief Medical Officer has been identified at most sites. Although nurses in Peru have been leaders in the multidrug resistant tuberculosis programs and in Haiti leading community health programs, their roles were often invisible to the larger global health community.

In 2010, a devastating earthquake hit the island of Haiti and PIH, with its sister organization, Zanmi Lasante, played a major role in the immediate humanitarian response. PIH's notoriety grew post-earthquake and the organization grew very quickly in response to the relief efforts. Prior to the earthquake, PIH did not have a nurse focused program, and the NGO was still considered a physician-centric organization. Donna Barry, MSN, MPH worked at PIH from 2001 to 2013 as the Policy and Advocacy Director and other PIH leaders strongly advocated for a formal nursing department at PIH, which became a reality in September of 2010.

The official PIH nursing program started with one full-time nurse based in Boston in 2010 and grew slowly for the first few years. Without a mandate, the strategy for nursing was to work with whomever wanted to collaborate and to become useful to the site teams, including creating relationships with nurses at partner sites. It was critical that known and trusted cross-site program colleagues provide a conduit to introduce to the cross-site nursing role. None of PIH's United States based clinicians (all provider types) oversee or mandate any care standards or programs. Rather they exist to provide support, consultation, and foster bidirectional learning. Lessons learned are quickly passed along to other countries.

The primary role of the US based Nursing Coordinator for the first year was to illuminate the role, talent, and extraordinary contributions of nurses working at PIH sites globally. Asking each site leader to identify a nurse leader at their site was more complicated than first thought. Although most sites could identify a physician lead, when asked for the nursing counterpart, there was some resistance to do so, for a number of reasons. Some sites had nurses leading different programs, such as TB and community health and did not want to pick one over another. Others reported they did not want to confuse reporting structures and they did not see the utility of using a nurse in this capacity. Overtime, however, the unique contributions of nursing and nursing leadership, albeit in multidisciplinary teams, gained recognition in the value brought to caring for patients and communities.

Since 2010 a number of sites, but not all have a Nursing Director or equivalent role. Through self-advocacy and organizational allies, the Nursing Coordinator position in 2010 evolved to a Nursing Director position in 2011. Although first presumed to fit under the Chief Medical Officer organizationally, the role has remained separate, reporting first to the COO and then to the CEO. The tension of wanting to continue to single out nursing as a separate distinct profession remains a challenge in a multidisciplinary care delivery system, since nursing historically has been so hidden at PIH. The author, Dr. Sheila Davis, is currently the Chief Operating officer of PIH and previously was the Chief Clinical Officer and Chief Nursing Officer.

24.4 PIH Model of Accompaniment

PIH's model is one of accompaniment, based on liberation theology articulated by a friend and mentor of Dr. Farmer, Father Gustavo Gutiérrez. Gutiérrez is a Peruvian priest who speaks of the "theology of accompaniment"—a lifelong practice of not only walking with people who are poor, but working to change the conditions that keep them poor (Griffin and Block 2013). This framework of PIH is actualized by not just working with local clinicians to provide health care during a cholera outbreak for example but also by joining the global advocacy movement to address access to clean water for the most vulnerable. An important component of accompaniment is *pragmatic solidarity*, the common cause of those in need paired with action. One can stand in solidarity with others, but pragmatic solidarity includes actively working to address the injustices that are causing and contributing to global health inequity.

Accompaniment in action is complicated but worth the complexity. It can be challenging to temper enthusiasm to address pressing issues impeding nursing care when the priorities of those who are being accompanied are different in favor of longer-term solutions to the complex challenges impacting patient care. Taking the time to listen and learn from the nurses who are the experts in care delivery in that context has been the key to successful partnerships. The authentic premise that we accompany each other has pushed the PIH nursing program forward. When we started treating oncology patients in Haiti and in Rwanda, PIH partnered with the Dana Farber Cancer Institute (DFCI) to bring nursing expertise in oncology care. The DFCI nurses spent months on the ground working in both countries and adapted best oncology nursing practice to both contexts, building upon local nursing expertise. The Rwandan and Haitian nurses trained by DFCI are now the experts in their countries and have trained countless numbers of other health professionals.

The success of PIH is in its cross-site collaboration between US based and in country staff. Expertise from Haiti, the longest standing country site for PIH has influenced every country site subsequently started. Rwanda, Malawi, and Lesotho sites were all started with on the ground leaders from Haiti working side by side with leaders from those countries. When PIH entered West Africa during the 2014–2015 Ebola outbreak in West Africa, PIH staff from Haiti and Boston led the teams on the ground. When the epidemic was under control and PIH stayed to address the underlying problem that allowed Ebola to take hold, which was a lack of a functioning health systems in Sierra Leone and Liberia. PIH staff from Haiti, Rwanda, Malawi, and Lesotho brought lessons learned from all PIH sites to set up the two new sites.

24.5 Nightingale Fellowship

Nursing education varies greatly in different countries across the globe. Although many nurses are put in management and leadership positions early in their career, they may have limited or absent education and training beyond basic care delivery.

With the goal of getting nurses at decision-making tables in the PIH countries, it became evident that not all nurses had the skills needed to succeed. Developing a monitoring and evaluation plan, creating slides to present programmatic data to a physician or Ministry of Health (MOH) colleagues, creating and managing budgets and writing funding proposals for donors are all skills that are needed for management and leadership but are lacking in nursing curricula in the vast majority of settings globally. Thus if we wanted nurses to succeed at the highest levels, we needed to create a program to provide those opportunities for learning.

Loosely based on the successful Robert Wood Johnson Foundation Executive Nurse Fellows program that ran from 1997 to 2017, the PIH Nightingale fellowship program was started in 2017. Nurse leaders from PIH country sites applied and five fellows were chosen for the inaugural class. One of the fellows withdrew due to personal circumstances but the remaining four fellows from Rwanda, Liberia, and Haiti continued. Fellows received foundational coursework in clinical and hospital management with a progressive development of critical analysis, health information systems, strengthening health systems, performance monitoring, evaluation and supervision, quality assurance, resource management, and customer relations. The fellowship included two in-person boot camps in Boston that included observations with nurse leaders from Boston's large academic medical centers, an opportunity which was widely valued by the fellows. Seeing a nurse leader in action working as the evening supervisor in a large academic medical center was inspirational and motivating. Opportunities to meet with and learn from supply chain, finance, communications, monitoring/evaluation, fundraising, and development teams based at PIH's Boston site was also invaluable for the fellows and the Boston staff and created opportunities for better workflow between the country site and the Boston office. In between in-person meetings there were online reading and discussion components, mentorship and coaching from nurse executives via phone, Skype, and in person.

The fellowship was very successful and each of the fellows has self-reported an increase in their confidence and ability to lead and represent nursing in various settings. All the fellows have remained engaged as alumni and have presented locally, nationally, and at international conferences. The program and curriculum are currently being adapted based on feedback from the fellows and a new class of fellows is due to start in 2020.

To ground some of the aforementioned discussion related to PIH, two PIH sites (Haiti and Liberia) will be highlighted to showcase the progression of nursing and its impact on patient care, PIH, and the nursing profession.

24.6 Haiti

24.6.1 History of Nursing in Haiti

Haiti like many countries amid a nursing shortage also has a geographic maldistribution of its health workers. Nearly 70% of nursing personnel work in Port Au Prince, the capital where roughly 30% of the population live, leaving the rural areas

desperate for qualified health professionals (Garfield and Berryman 2010, 2012; Ministry of Health 2017).

Nursing education in Haiti has been affected by structural and economic factors that have limited nursing practice and health outcomes (Louis 2018). These include a nursing faculty shortage, overcrowded classrooms, limited access to technology, and inadequate clinical sites and instructors (Baumann and Alexandre 2016; Knebel et al. 2008; Murray et al. 2011). The country has many nursing schools, primarily private, but only 32 are recognized by the Haitian Ministry of Health because of inadequate regulation and credentialing of private institutions (Partners In Health 2014). The country's public nursing schools prepare graduates through a 3-year, professional, generalist nurse diploma program. Graduates of these programs take a national exam, which is a requirement for registration. Plans to implement a four-year bachelor's degree have been delayed indefinitely in the wake of the 2010 earthquake. The country is in the infancy state of implementing a standardized nursing curriculum and to introducing specialties to help diversify nursing's scope of practice. Despite these challenges nursing personnel make up the majority of the health care workforce in Haiti and are integral to its functioning. The advanced practice nurse role in Haiti is an emerging one with PIH working extensively with the MOH to developing its scope role and piloting it at HUM. HUM currently has nurse practitioners in the public health and community health sector but it is still evolving as a cadre.

24.6.2 Partners In Health History in Haiti

Partners In Health's work began in Haiti in 1983 in partnership with two of the organization's founders Dr. Paul Farmer and Ophelia Dahl and Haitian physicians, nurses and leaders in Cange a settlement in Haiti's central plateau to establish a community-based health project. In 1987 the organization was formally founded in Boston to support the work taking place in Cange and joined Zanmi Lasante, translated into Partners In Health in Creole, a sister organization in Haiti (Partners In Health 2010). Today, Zanmi Lasante is the largest health care provider in some of the most rural parts of Haiti and provides health care for 4.5 million people in partnership with the Ministry of Health (Partners In Health n.d.)

24.6.3 Mirebalais Hospital

After the 2010 earthquake destroyed most of the public health infrastructure, main hospital and nursing school in Port au Prince the Haitian Ministry of Health asked PIH to massively scale up their existing plans to build a small hospital in Mirebalais, a small community about 60 miles from the capital. The result was Hôpital of Mirebalais (HUM) a 205,000 square foot, 300 bed teaching facility which opened in 2013 and quickly filled both a local and national void of providing care for Haitians seeking care and training a new generation of Haitian health care

providers. HUM is Haiti's and the Caribbean's largest teaching hospital serving over 3.1 million people for primary, secondary, and tertiary care (Partners In Health 2013).

With the emergence of a new hospital, HUM served as a wonderful opportunity to strengthen the nursing profession and allow it to assume its rightful position as one of many important professional cadres needed to deliver care to the Haitian people. When HUM's new nursing administration team was being put together in March 2013 the physical structure of the buildings were complete, thus much of the teams' efforts were focused on building the nursing infrastructure at the ground level. This included organizing policies, standard operating procedures, and interviewing and hiring new staff to prepare for an initial soft opening of the hospital. Marc Julmisse, MPH, RN, HUM CNO, remembers those early days when she was building her team from scratch. Marc noted, "we instituted a process called confirmation-which really sought people who had more than just technical expertise. We really wanted to make sure we hired people who shared the mission and vision of the institution (HUM) and nursing as well because those who understand the vision can contribute to it and are the best at working in these environments."

Acquiring members on her team with both technical skill and vision would be imperative with the challenges nursing faced in the initial days at HUM. It was important for nursing to have a voice and presence within the administrative level of the hospital as nurses were the most abundant in numbers but also closest to the patients and their needs. Having nurses not serve as mere figureheads was important to nursing staff and administration at both headquarters in Boston and Haiti. Marc remembered, "it took a while for people to see nursing as an integral part of the hospital team; operations needed to change to be more reflective of the realty of the clinical scene." But through this process the importance of allies, identifying nursing champions among physicians, communicating with various departments to promote transparency and collaborative partnerships all better positioned nurses to contribute to both unit level and organizational conversations taking place.

Much of Haiti's medical system, as is the case in many parts of the world, is very patriarchal and centered on the medical model, which often devalues nursing, leaving it in a dependent position regarding its autonomy and decision-making capabilities. Recognizing the persistent challenges Haitian nurses face and wanting to groom a new generation and culture of critically thinking, astutely confident nurses, PIH and Zanmi Lasante opened the nursing center of excellence at HUM in 2014. The center serves as a hub for mentorship, leadership, and professional nursing growth in an effort to raise the standard of nursing in Haiti. The center allows nurse managers and staff to have observations and rotations in other countries in order to awaken their possibilities of what can be implemented at HUM. By being exposed to various models of how nursing is practiced HUM nurses can bring home what they learn, adapt it to their local context, and make it their own. In addition, nurses are coached on effective communication, so when they are present at the decision-making table, they can maximize those efforts to speak about topics that directly affect patient care but also the nurses who provide that care.

After 6 years of investment in nursing human resources for health at HUM, nursing has undergone transformative growth. Nurses are more comfortable with making decisions and recognize the need to be part of the decision-making process as leaders. Marc Julmisse, HUM CNO added, "there is more confidence within nurses and their confidence in their abilities and others [non-nurses] confide in them. They are able to articulate and advocate their needs." In the age of brain drain and nurse migration, HUM has also sought to minimize knowledge losses among staff. HUM has instituted systems to facilitate a knowledge retention environment-one where coaching takes place at each level of nursing to ensure sustainability and growth. The CNO coaches deputy CNOs, nurse managers coach team leaders on the unit, and so on. This initiative ensures that knowledge will not be lost among staff in the event current leadership is no longer present.

24.7 Liberia

24.7.1 Nursing in Liberia

Liberia's formal nursing education system was initiated in the 1920s by numerous faith-based initiatives from various denominations. Initially, early entry requirements for professional nursing programs were an eighth grade education, but these have been reviewed and updated numerous times to obtain equal status and reciprocity with colleagues in other countries (Klopper and Uys 2013). Nursing education has grown from hospital-based training to institutions with post basic nursing education programs in country (Klopper and Uys 2013). Currently, the country has both 3 year associate degree/diploma options and a 4 year bachelor of science in nursing degree (Klopper and Uys 2013). Degree holders are required to take a national licensing exam to obtain their registered nurse licensure. In addition to the RN cadre, Liberia also has licensed practical nurses, certified midwives, nurse midwives, nurse anesthetists, ophthalmic nurses, and nurses' aides to round out the country's nursing workforce each with their specific requirements for training and licensure. Liberia's MOH is currently considering the role of the advanced practice registered nurse but has not formally initiated the process yet.

24.7.2 Partners In Health in Liberia and J. J. Dossen Hospital

PIH responded to the 2014 Ebola outbreak at the request of the Liberian government and partnered with the Ministry of Health, other NGO's, and other partners to combat the epidemic. PIH also responded to the outbreak in neighboring Sierra Leone. Recognizing that Ebola was a symptom of a non-functioning health system and a longer-term strategy was needed beyond an emergency response, PIH committed to staying in both Liberia and Sierra Leone. At the request of the Liberian Government, PIH focused their efforts on Maryland County, an isolated Southeast region with 100,000 inhabitants, at least a 10-h drive from Monrovia when roads are accessible.

Once Ebola was under control, PIH refocused their efforts fully on re-building a health system in Maryland County which by now had hired a new Kenyan nurse administrator charged with reshaping and revamping J. J. Dossen Hospital. Thereafter J. J. Dossen, the region's main public health hospital, was supported by PIH and the ministry of health.

When Viola Karanja, arrived in Maryland Country in June 2015 she was not fazed by the physical devastation she saw having worked prior in South Sudan. Liberia's health care system was debilitated, not only because of Ebola which kept patients away from health care facilities for fear of contracting the disease, but also the aftermath of the country's longstanding civil war. The war was the primary reason for neglect, inadequate resources, and a frustrated health workforce who work with little to no equipment or medications to care for patients.

Viola realized the physical and infrastructural components were only a small facet of the true work that needed to be done. She quoted, "coming in as a new person, an outsider, I was cautiously walking the line of not wanting to give too much hope to the nursing staff but emphasizing that I wanted to work with them and gaining their trust was important." Understandably, the nurses and staff reluctance at J. J. Dossen hospital was an all too familiar story. Outside NGOs often infiltrate areas in need make promises of change, and then fail to deliver, leaving before any work or sustainable impact can be measured or created.

Viola knew the only way to be able to create a change on a system's level, which would improve patient outcomes, obtain more resources for the facility and empower the nurses working with her, was to work to win their confidence and trust. She implemented her strategic plan by recruiting Liberian nurse nationals, hereafter Liberian nationals, throughout the country with whom she could work and mentor to serve as liaisons and facilitators to fellow Liberian colleagues at J. J. Dossen. She enlisted Liberian nationals to buy into her vision. These nurses then served as allies to alleviate fears of the nursing staff at J. J. Dossen who had negative perceptions of Viola as an outsider. Next, she created her vision which was threefold. First, she envisioned nurses as leaders, leaders who have the power to improve the quality of patient care, are clinically competent and advocate for their own profession. Second, she envisioned nurses obtaining specialized training to be clinical experts as one method for succession planning, building the capacity of junior nursing staff, and reducing the need for external experts. Third, she saw nurses as innovators, who had the knowledge, ability, and skillset to creatively tackle complex challenges impacting patient care.

So how did this mentorship process evolve from a small group of Liberian nationals to an entire nursing staff at J. J. Dossen? It was a gradual and arduous process; one that does not necessarily have the fanfare of opening a new state of the art operating theater or generating a great number of positive outcomes quickly that NGOs love to report to funders. The initial training and relationship building with the Liberian nationals took about 6 months. The Liberian nationals also skeptical of Viola at first, soon realized she was in this for the long term as she continually emphasized that all ideas for change and improvement were on the table. Having Liberian nationals serve as liaisons proved to be a valuable lesson to obtaining

nursing staff buy-in at the hospital level. Once the initial group of Liberian nationals saw her vision, discussed it, modified it, and made it their own, they bought into it. On Viola's end, she immersed herself into her new surroundings and sought to better understand Liberian culture, what nursing signified in Liberia, and the history and current state of J. J. Dossen.

Once the Liberian nationals were able to make inroads with the nursing staff and gain their trust and support in working with Viola, the foundation for change was created. From relationship building, the focus then shifted to creating and expanding the knowledge base of nurses at the hospital through initiatives such as a journal club, which critiqued evidenced based literature and discussed patient cases and conditions to improve patient care. In addition, nurses were sent to other countries for trainings on specialized topics and regional and international experts were brought to J. J. Dossen to conduct workshops and improve clinical skills. Now, 5 years later skill levels have increased, and home-grown experts/leaders have been cultivated at the hospital. In addition, the nursing staff is looking to implement a more evidence-based approach into their work, incorporating data collection and translation of research to support efforts for quality improvement and eventual research at the hospital to improve patient outcomes.

Complementing the increased technical competence of staff, gradual investments from the MOH and PIH have improved the hospital's physical infrastructure. This was done with input from nursing staff to improve overall patient care. The emergency department has doubled its bed capacity, there are two newly renovated operating rooms and the hospital has access to water and electricity 24 h a day. Those investments have enhanced the working environment which in turn has improved staff morale and motivation. All these pieces are working simultaneously, one building on the other to create a better nursing staff.

Currently, leadership is taking precedence in grooming the next generation of nurse leaders at J. J. Dossen. More specifically they are asking, how do you lead people, how do you communicate in the wards and with other leaders as part of an interdisciplinary team? Viola shared a vignette describing how nursing practice and leadership has changed for the better at J. J. Dossen Hospital since 2015.

In 2015 and 2016 nursing supervisors and managers did not view themselves responsible for the functioning of their wards and the quality of care their staff provided. Consequently, they also did not believe they had a responsibility to advocate for anything that was needed for nurses to do their job. Rather they deemed it a management issue, not a part of their job description. Bedside nurses struggled with staying motivated at work due to a lack of resources to care for their patients and no pathway to advocate for themselves or their patients. Liberia's patriarchal medical system exacerbated these challenges as decisions were made on behalf of nurses without their input. This resulted in apathy toward nursing practice as nurses had no autonomy over their scope of practice and no ability to advocate for the necessary stuff, staff, space, and systems needed to improve patient care. Through mentorship with Viola and her team from the management level down to the bedside nurse, change slowly started to take shape. Supervisors began to feel empowered to make decisions that affected their wards and nursing staff by understanding and making it

their priority to know what issues were taking place on their wards. Nurses began to better comprehend what they needed to be more efficient care providers and how to advocate for patients and themselves. Hospital administration began to see nurses and nurse management advocate for supplies and organize among themselves. Consequently, nurses from individual wards and collectively as an institution now meet on a monthly basis to share ideas and experiences but also create solutions to deal with the problems they are facing. They are better equipped to ask for resources to improve their workflow daily and with support from MOH and PIH know that improvements will continue to be made.

The hospital still faces numerous challenges but the impact and ability of Viola and her team to obtain buy-in from the staff she was working in concert with was paramount to achieving their goals. The sense of empowerment that nursing has gained at J. J. Dossen will be sustainable for years to come as there is a new understanding of the importance in investing in nursing leadership and support for ongoing professional development. This has created a leadership pipeline that is not reliant on any one individual and has changed the culture of nursing practice and patient care at J. J. Dossen. Within the 5 years, PIH has been at the hospital, nurses are now more respected as leaders in the interdisciplinary team, can better voice their needs, make decisions, and contribute their successes to the broader global nursing dialogue.

24.8 Conclusion

In the 9 years since the inception of the formal nursing program at PIH, tremendous growth has occurred in the acknowledgment of the unique role and contributions of the thousands of nurses who have or are currently working across PIH globally. Just as the global health community has recognized the leadership of PIH physicians for decades, PIH nurses are starting to be heard and their contributions to health care equity recognized. The talent and resiliency of the nurses, who work in the community and at the bedside, to the leadership tables and everywhere in-between, has changed the lives of millions. PIH as an organization is committed to supporting nurse leaders like Marc Julmisse and Viola Karanja and the many others who they themselves are mentoring and bringing their leadership to the table.

The stories of the nurses working in Liberia and Haiti are not unique to those two countries and are emblematic of the evolution of the nursing profession globally. Although great strides have been taken, and successes to celebrate, nursing leaders everywhere need to be vocal and insist on inclusion of nurses at decision-making tables. Nurses currently in positions of power need to use their influence and authority to give other nurses opportunities and mentor them for success. Having nurses in leadership positions is not only important to our profession for recognition and advancement, it is best for patients and communities. Universal Health coverage will not be obtained globally unless nurses and midwives are valued and positioned to address global health equity.

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Correction to: Advanced Practice Nursing in Africa

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An incorrect data and information have been used in Chapter 6 on page 67. A correct data has been updated as below:

An earlier one-year certificate educational program introduced the family practice role in Swaziland between 1979–1995. This program was presented through a partnership between University of Swaziland and Denmark. Various barriers to this programme contributed to the decision to develop the family practice role at a master's level as an advanced practice nurse practitioner role. The PEPPA framework (Participatory, Evidence-based, Patient focused Process for Advanced practice nursing) (Bryant-Lukosius and DiCenso 2004) provided the context for the development and implementation of the nurse practitioner role in Eswatini starting with stakeholder consultations in 2004–2007. This was followed by role definition, educational preparation and policy/regulatory requirements including the development of a scope of practice. The curriculum was approved by the university in 2016 and the first students were enrolled in 2017. The Global Health Service Partnership (GHSP: a partnership between US Peace Corps, PEPFAR, and Seed Global Health) provided experienced nurse practitioner faculty for a year to support the family practice nursing program until a core family practice nurse faculty could be developed. One GSHP faculty stayed on as program coordinator to provide continuity and expertise to fully develop the program (Dalmini et al. 2020).

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