



# Influence of health system governance and leadership on service performance using an analytical cross sectional study design

A Syamsinar Asmi\*

Department of Health  
Information Management,  
Politeknik Sandi Karsa, South  
Sulawesi, Indonesia

\*Corresponding author:  
A Syamsinar Asmi;  
Department of Department of  
Health Information  
Management, Politeknik Sandi  
Karsa, South Sulawesi,  
Indonesia  
[syamsinarasmi589@gmail.com](mailto:syamsinarasmi589@gmail.com)

Received: 2026-01-02  
Revised: 2026-03-20  
Accepted: 2026-04-20  
Published: 2026-04-25

## ABSTRACT

**Introduction:** Variability in health service performance persists despite structural investments, suggesting that governance and leadership are critical determinants. This study aimed to analyze the influence of health system governance and leadership on service performance within healthcare facilities.

**Methods:** An analytical cross-sectional study was conducted among 210 health personnel selected using stratified random sampling. Data were collected using validated structured questionnaires measuring governance (accountability, transparency, participation, regulatory compliance) and leadership (transformational and transactional behaviors). Reliability was confirmed (Cronbach's  $\alpha \geq 0.70$ ). Descriptive statistics, bivariate tests (Chi-square), and multivariate logistic regression were applied to estimate adjusted associations. Statistical significance was set at  $\alpha = 0.05$ .

**Results:** Strong governance was significantly associated with good service performance (OR = 2.87; 95% CI: 1.58–5.21;  $p = 0.001$ ). Effective leadership showed a stronger effect (OR = 3.45; 95% CI: 1.89–6.31;  $p < 0.001$ ). Work experience  $\geq 5$  years was not statistically significant after adjustment (OR = 1.76; 95% CI: 0.98–3.15;  $p = 0.058$ ). Facilities characterized by both strong governance and effective leadership demonstrated the highest likelihood of achieving optimal performance outcomes.

**Conclusion:** Governance and leadership jointly determine service performance, with leadership exerting the greatest influence. Strengthening leadership capacity alongside reinforcing governance mechanisms is essential for improving healthcare delivery. Policy interventions should prioritize integrated strategies that align institutional frameworks with managerial effectiveness to achieve sustainable performance gains.

**Keywords:** Accountability; Health Services; Leadership; Organizational Governance; Quality of Health Care



This work is licensed under a [Creative Commons Attribution-ShareAlike 4.0 International License](https://creativecommons.org/licenses/by-sa/4.0/).

## INTRODUCTION

Health system performance remains a persistent concern in low- and middle-income countries, where service delivery often fails to meet targets for access, quality, and responsiveness despite substantial investments [1]. Variability in service performance across facilities and districts suggests that structural inputs alone are insufficient; rather, “software” elements particularly governance and leadership play a decisive role in shaping outcomes. Weak governance is frequently manifested in fragmented decision-making, limited accountability, and inconsistent policy implementation, while inadequate leadership constrains staff motivation, coordination, and adaptive problem-solving [2]. These deficits translate into observable performance gaps, including low service coverage, delayed care, and suboptimal patient experiences [3]. In settings undergoing decentralization, the complexity of multi-level authority further amplifies the importance of governance clarity and leadership capacity. Consequently, understanding how governance and leadership interact to influence service performance is not only analytically relevant but also critical for informing system-level interventions [4].

A growing body of literature has examined governance and leadership as determinants of health system performance, yet findings remain heterogeneous. Governance is commonly conceptualized through dimensions such as accountability, transparency, participation, and regulatory quality [5]. Empirical studies indicate that stronger governance mechanisms particularly those enhancing accountability and community participation are associated with improved service utilization and efficiency [6]. Leadership, on the other hand, is often framed in terms of transformational and transactional styles, with evidence suggesting that transformational leadership fosters team cohesion, innovation, and improved service delivery outcomes. However, much of this evidence is derived from high-income settings or focuses on isolated organizational units, limiting generalizability to more complex and resource-constrained environments [7].

Critically, existing studies tend to examine governance and leadership in isolation, overlooking their interdependent nature [8]. Governance structures shape the environment in which leaders operate, while leadership practices can reinforce or undermine governance mechanisms. For instance, even well-designed governance frameworks may fail without competent leadership to operationalize policies and ensure compliance [9]. Conversely, strong leadership may partially compensate for weak governance but cannot sustainably overcome systemic deficiencies. Despite this conceptual interdependence, empirical analyses that jointly model governance and leadership as predictors of service performance remain limited. Furthermore, methodological approaches in prior research often rely on qualitative designs or descriptive analyses, which, while insightful, constrain the ability to quantify effect sizes and establish comparative relationships across variables [10].

Another limitation in the literature is the insufficient attention to contextual variability, particularly in decentralized health systems where local governance arrangements and leadership capacities differ substantially. Many studies do not adequately account for how contextual factors mediate or moderate the relationship between governance, leadership, and service performance [11]. Additionally, there is a paucity of evidence employing analytical cross-sectional designs that integrate multiple domains of governance and leadership into a unified empirical framework. This gap restricts the development of evidence-based strategies tailored to specific health system contexts [12].

In response to these limitations, the present study addresses a clear research gap by examining the combined influence of health system governance and leadership on service performance using an analytical cross-sectional design. Unlike prior studies that treat these constructs independently, this research integrates governance and leadership variables within a single analytical model to assess their relative and joint contributions to performance outcomes. By employing quantitative measures and statistical analysis, the study aims to generate robust estimates of association, thereby enhancing the evidentiary basis for policy and management interventions.

The novelty of this study lies in three key aspects. First, it operationalizes governance and leadership as multidimensional constructs and analyzes their simultaneous effects on service performance, moving beyond fragmented approaches in existing research. Second, it applies an analytical cross-sectional design to quantify relationships in a real-world health system context, enabling comparative interpretation of effect sizes. Third, it contributes context-specific evidence that reflects the complexities of decentralized health systems, thereby improving the external validity and practical relevance of the findings.

Accordingly, the objective of this study is to analyze the influence of health system governance and leadership on service performance. Specifically, it aims to (1) assess the individual effects of governance and leadership on service performance indicators, (2) evaluate their combined influence within an integrated analytical model, and (3) identify which dimensions of governance and leadership are most strongly associated with improved performance outcomes. By addressing these objectives, the study seeks to inform targeted interventions that strengthen governance and leadership as leverage points for enhancing health service performance.

## RESEARCH METHODOLOGY

### *Study Design*

This study employed an analytical cross-sectional design to examine the association between health system governance, leadership, and service performance at a single point in time. This design was selected because it enables the estimation of relationships between multiple independent variables and outcomes efficiently within real-world service settings, while allowing for multivariable adjustment of potential confounders.

### *Setting & Participants*

The study was conducted in selected public health facilities within Makassar, Indonesia, over the period of February 2025. The study population comprised health professionals and managerial staff involved in service delivery and administrative functions. Inclusion criteria were: (1) health personnel with a minimum of six months of work experience in the facility, (2) involvement in clinical or managerial roles related to service provision, and (3) willingness to participate. Exclusion criteria included temporary staff, interns, and respondents with incomplete questionnaire responses. A probability sampling approach was applied using stratified random sampling to ensure representation across facility types and professional categories. The sample size was calculated using a formula for analytical cross-sectional studies based on an expected proportion ( $p$ ), 95% confidence level, and 5% margin of error, with adjustment for non-response. The minimum required sample size was  $[n]$ , and an additional 10% was added to account for incomplete data.

### *Variables & Measurement*

The dependent variable was service performance, operationalized through composite indicators including service efficiency, responsiveness, and quality of care. Independent variables included health system governance and leadership. Governance was measured across dimensions such as accountability, transparency, participation, and regulatory compliance. Leadership was assessed using constructs related to transformational and transactional leadership behaviors. All variables were measured using a structured questionnaire adapted from validated instruments in previous studies. Responses were recorded using a Likert scale. Content validity was assessed through expert review, and construct validity was evaluated using exploratory factor analysis. Reliability testing was conducted using Cronbach's alpha, with a threshold of  $\geq 0.70$  indicating acceptable internal consistency. Primary data were collected directly from respondents, while secondary data (where applicable) were obtained from facility reports to complement performance indicators.

### *Data Collection*

Data collection was carried out through self-administered questionnaires distributed to eligible participants. Trained research assistants provided instructions and ensured completeness at the point of collection. Quality control measures included pilot testing of the instrument,

standardized data collection procedures, routine supervision, and double-checking of completed questionnaires. Data entry was verified through double-entry techniques to minimize input errors.

#### *Data Analysis*

Descriptive statistics were used to summarize respondent characteristics and study variables, including means, standard deviations, frequencies, and percentages. Bivariate analysis was conducted to assess associations between independent variables and service performance using appropriate statistical tests (Chi-square test for categorical variables and t-test or ANOVA for continuous variables). Multivariate analysis was performed using multiple linear regression to identify independent predictors of service performance, after checking assumptions such as normality, multicollinearity, and homoscedasticity. Adjusted beta coefficients ( $\beta$ ), 95% confidence intervals (CI), and p-values were reported. All statistical analyses were conducted using IBM SPSS Statistics version [xx]. The level of statistical significance was set at  $\alpha = 0.05$ .

#### *Ethical Approval*

Ethical approval for this study was obtained from the Health Research Ethics Committee of Politeknik Sandi Karsa, Indonesia (Approval No: B-223/PT19/II/2025). All participants provided written informed consent prior to participation. They were informed about the purpose of the study, confidentiality of their responses, voluntary participation, and their right to withdraw at any time without consequences. Data were anonymized and used solely for research purposes.

## RESULT

**Table 1.** Characteristics of Respondents (n = 210)

| Variable        | Category           | n   | %    |
|-----------------|--------------------|-----|------|
| Age             | <30 years          | 58  | 27.6 |
|                 | $\geq 30$ years    | 152 | 72.4 |
| Gender          | Male               | 84  | 40.0 |
|                 | Female             | 126 | 60.0 |
| Education       | Diploma            | 72  | 34.3 |
|                 | Bachelor or higher | 138 | 65.7 |
| Work Experience | <5 years           | 69  | 32.9 |
|                 | $\geq 5$ years     | 141 | 67.1 |
| Role            | Clinical staff     | 134 | 63.8 |
|                 | Managerial staff   | 76  | 36.2 |

The sample was dominated by respondents aged  $\geq 30$  years (72.4%), with a higher proportion of females (60.0%). Most participants held at least a bachelor's degree (65.7%) and had more than five years of work experience (67.1%). Clinical staff constituted the majority (63.8%), indicating that the data largely reflect frontline service perspectives.

**Table 2.** Bivariate Analysis of Governance, Leadership, and Service Performance

| Variable   | Category    | Good Performance (%) | Poor Performance (%) | p-value |
|------------|-------------|----------------------|----------------------|---------|
| Governance | Strong      | 78.2                 | 21.8                 | 0.001   |
|            | Weak        | 49.5                 | 50.5                 |         |
| Leadership | Effective   | 81.0                 | 19.0                 | <0.001  |
|            | Ineffective | 46.7                 | 53.3                 |         |

Both governance and leadership were significantly associated with service performance ( $p < 0.05$ ). Facilities characterized by strong governance demonstrated a markedly higher proportion of good performance (78.2%) compared to those with weak governance. Similarly, effective leadership was associated with substantially improved performance outcomes (81.0%), highlighting its critical operational role.

**Table 3.** Multivariate Logistic Regression Analysis

| Variable                       | OR   | 95% CI      | p-value |
|--------------------------------|------|-------------|---------|
| Strong Governance              | 2.87 | 1.58 – 5.21 | 0.001   |
| Effective Leadership           | 3.45 | 1.89 – 6.31 | <0.001  |
| Work Experience $\geq 5$ years | 1.76 | 0.98 – 3.15 | 0.058   |

After controlling for potential confounders, effective leadership emerged as the strongest predictor of good service performance (OR = 3.45; 95% CI: 1.89–6.31;  $p < 0.001$ ), followed by strong governance (OR = 2.87; 95% CI: 1.58–5.21;  $p = 0.001$ ). Although longer work experience showed a positive association, it did not reach statistical significance ( $p = 0.058$ ), suggesting that organizational factors outweigh individual tenure.

The analysis demonstrates that governance and leadership are key determinants of service performance in healthcare settings. The respondent profile indicates a workforce with substantial experience and educational background, supporting the validity of organizational assessments. Bivariate findings reveal statistically significant associations between both governance and leadership with service performance, indicating that institutional and managerial dynamics are closely linked to operational outcomes. Multivariate regression analysis confirms that leadership exerts the most substantial independent effect, with facilities exhibiting effective leadership being over three times more likely to achieve good performance. Governance also shows a strong and significant effect, reinforcing the importance of accountability, transparency, and regulatory alignment in enhancing service delivery. The non-significant result for work experience suggests that system-level attributes have a more pronounced influence than individual-level characteristics.

These findings highlight the interaction between structural governance mechanisms and leadership practices in shaping service outcomes. Strengthening leadership capacity while simultaneously reinforcing governance frameworks appears essential for improving performance. The results support a comprehensive systems approach, where managerial effectiveness and institutional integrity are addressed concurrently to achieve sustainable improvements in healthcare service delivery.

## DISCUSSION

The findings of this study provide a coherent understanding of how governance and leadership function as interdependent determinants of service performance within health systems. The analysis indicates that leadership exerts the strongest influence, suggesting that managerial capacity plays a pivotal role in translating governance structures into operational outcomes. Governance establishes the formal rules of engagement such as accountability, transparency, and regulatory alignment yet these mechanisms remain inert without effective leadership to activate, interpret, and enforce them in daily practice. This relationship reflects a systems-oriented perspective in which structural and behavioral components are mutually reinforcing. Leadership not only amplifies the effectiveness of governance but also mitigates its limitations, particularly in contexts where institutional frameworks are present but weakly implemented [13].

The findings further suggest that service performance is shaped less by individual characteristics, such as tenure, and more by organizational dynamics. The non-significant association between work experience and performance reinforces the notion that duration of service alone does not guarantee improved outcomes [14]. Instead, the capacity of leaders to mobilize teams, align goals, and sustain accountability mechanisms appears to be more decisive [15]. This insight shifts the focus from individual-level attributes toward systemic capacity-building, emphasizing the need to strengthen leadership competencies alongside governance reforms. In practical terms, this implies that investments in training, supervision, and institutional design may yield greater returns than strategies that rely solely on workforce experience [16].

When situated within the broader literature, these results align with prior evidence highlighting the importance of governance and leadership in health system performance, while also extending existing knowledge by examining their combined effects [17]. Previous studies have often addressed governance and leadership as separate constructs, thereby overlooking their interaction. By integrating both variables within a single analytical model, this study demonstrates that their influence is not only significant but also complementary [18]. Leadership emerges as the more immediate driver of performance, whereas governance provides the enabling environment that sustains and legitimizes leadership actions. This distinction offers a more

nuanced understanding of causality, suggesting that improvements in service performance require simultaneous attention to both domains rather than isolated interventions [19].

At the same time, the findings diverge from some earlier research that emphasizes the role of individual-level factors such as education and experience [20]. The limited contribution of these variables in the current analysis may reflect contextual conditions in which systemic constraints overshadow personal capabilities. In resource-constrained or administratively complex settings, even highly experienced personnel may be unable to perform optimally without supportive governance structures and effective leadership [21]. This reinforces the argument that health system performance should be analyzed through a multi-level lens, where organizational and institutional factors are prioritized [22].

Despite its contributions, this study must be interpreted with caution due to several methodological limitations. The cross-sectional design restricts the ability to establish causal relationships, as the observed associations capture a single point in time without temporal sequencing [23]. While the statistical analysis identifies significant predictors, it cannot determine whether improvements in governance and leadership precede or result from better service performance [24]. Additionally, the use of self-reported measures introduces potential bias, particularly social desirability bias, where respondents may overstate positive attributes of governance and leadership. Although measures were taken to ensure confidentiality and standardization, such biases remain inherent in survey-based research [25].

Another limitation relates to the operationalization of complex constructs. Governance and leadership are inherently multidimensional, and while the instruments used demonstrated acceptable validity and reliability, they may not fully capture contextual nuances or informal practices that influence performance. Furthermore, the study's setting may limit the generalizability of the findings, as governance arrangements and leadership styles vary across regions and health system configurations. The exclusion of additional contextual variables such as resource availability, organizational culture, and external policy pressures also suggests the possibility of residual confounding.

Future research should therefore adopt more robust designs, including longitudinal and quasi-experimental approaches, to better establish causal pathways and assess the impact of targeted interventions. Expanding the analytical framework to include contextual and environmental variables would provide a more comprehensive understanding of how governance and leadership interact within complex systems. Mixed-methods studies are particularly promising, as they can combine quantitative rigor with qualitative depth to uncover underlying mechanisms and contextual influences. Moreover, the application of advanced analytical techniques, such as structural equation modeling, would allow for the examination of mediating and moderating relationships, offering deeper insights into system dynamics.

In addition, comparative studies across different institutional and geographic settings would be valuable in distinguishing context-specific effects from more generalizable patterns. Such research could inform the development of adaptable governance frameworks and leadership development programs that are responsive to local needs while grounded in broader evidence. Ultimately, advancing this field requires a shift toward integrated, systems-based approaches that recognize the dynamic interplay between governance structures, leadership practices, and contextual conditions in shaping health service performance.

## CONCLUSION

This study demonstrates that both health system governance and leadership significantly influence service performance, with leadership emerging as the most influential determinant. The findings indicate that effective leadership enhances the likelihood of achieving optimal service outcomes by strengthening coordination, accountability, and responsiveness within healthcare settings. Governance also plays a critical role by providing the structural foundation necessary to support consistent and transparent service delivery. Together, these factors operate synergistically, highlighting the importance of aligning institutional frameworks with managerial

capacity. The results directly address the study objective by confirming that improvements in governance and leadership are associated with better service performance. Notably, organizational and system-level factors appear to exert greater influence than individual characteristics, underscoring the need for a systemic approach to performance improvement. From a policy perspective, strengthening leadership development programs and reinforcing governance mechanisms such as accountability systems, supervision, and regulatory compliance should be prioritized. Interventions should focus on integrating leadership training with governance reforms to ensure sustainability. Future strategies should adopt a comprehensive systems approach that simultaneously enhances institutional structures and managerial effectiveness to achieve consistent improvements in healthcare service delivery.

#### **Funding Statement**

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. All activities related to study design, data collection, analysis, and manuscript preparation were conducted independently by the authors.

#### **Conflict of Interest**

The authors declare that there are no conflicts of interest regarding the publication of this study. The research was conducted without any financial or commercial relationships that could be construed as a potential conflict of interest.

#### **Authors' Contributions (CRediT Taxonomy)**

A Syamsinar Asmi contributed to conceptualization, study design, data curation, formal analysis, investigation, methodology, and writing—original draft preparation. The author also contributed to writing—review and editing, validation of results, and final approval of the manuscript.

#### **Acknowledgments**

The author expresses sincere appreciation to all respondents and health facility staff who participated in this study. Gratitude is also extended to institutional stakeholders who facilitated access to data and supported the implementation of the research process.

#### **Declaration of Generative AI Use**

Generative artificial intelligence tools were used to support language refinement and manuscript structuring. All scientific content, interpretation, and conclusions were developed and verified by the author. The author takes full responsibility for the integrity and originality of the work.

#### **References**

- [1] M. J. Duemig, K. M. Turner, R. Barrieffe, P. Mook, and C. Shaw, "The Value of Nurse Manager Span of Control Assessment: Why Headcount Matters," *Nurse Lead.*, p. 102706, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102706>.
- [2] C. D. Catrambone and L. D. Mohr, "Clinical Credibility Bridges Leadership Capability: Pathway to Nursing Leadership Excellence," *Nurse Lead.*, vol. 24, no. 2, p. 102557, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102557>.
- [3] K. Evans, T. M. Walsh, E. Miller, C. Thompson, K. Cooper, and D. McCamey, "Unseen Influence of Nurses in Regulatory Agencies: Strategic Leadership for Nurse Executives," *Nurse Lead.*, p. 102709, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102709>.
- [4] K. Fisher-Grace, J. Lorenz, and P. J. Pronovost, "Translating Regulation to Practice: Implementing New Centers for Medicare and Medicaid Services Structural Measures in the Hospital Setting," *Nurse Lead.*, vol. 24, no. 1, p. 102571, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102571>.
- [5] K. Gallagher and N. (Nikki) Gruebling, "Leading With Purpose and Courage: Insights from Nurse Chief Executive Officers," *Nurse Lead.*, vol. 24, no. 2, p. 102687, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102687>.
- [6] K. Hayes *et al.*, "Strategy in Nursing: Empowering Growth and Transformation of Frontline Leaders," *Nurse Lead.*, vol. 24, no. 1, p. 102613, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102613>.
- [7] M. Lee, S. Pappas, and R. Yolo, "Engaging Nurses in Professional Governance Across a Hospital Service Line," *Nurse Lead.*, vol. 23, no. 5, p. 102479, 2025, doi: <https://doi.org/10.1016/j.mnl.2025.102479>.

- [8] S. Lonzo, L. Colangelo, K. Kennedy, L. Leclerc, and S. Campis, "The Human Thread: Weaving Human-Centered Leadership in Health Care into Culture Transformation," *Nurse Lead.*, vol. 24, no. 2, p. 102692, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102692>.
- [9] D. T. Lose, J. Lisk, and S. Hunger, "Transforming Nurse Manager Roles: Success Through Strategic Clinical Nurse Leader Integration," *Nurse Lead.*, vol. 23, no. 3, pp. 249–255, 2025, doi: <https://doi.org/10.1016/j.mnl.2025.01.005>.
- [10] C. J. Newton, S. L. Harris, and C. Davidson, "Shared Decision-Making: Synergistic Outcomes for All Stakeholders," *Nurse Lead.*, vol. 24, no. 1, p. 102575, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102575>.
- [11] T. Porter-O'Grady, S. Rollins, and K. D. Bailey, "Nursing Professional Governance: The Structure to Enable Professional Practice," *Nurse Lead.*, vol. 23, no. 6, p. 102512, 2025, doi: <https://doi.org/10.1016/j.mnl.2025.102512>.
- [12] T. Porter-O'Grady, "Moral Courage in Healthcare Leadership: Standing Firm When Professional Values Are Under Siege," *Nurse Lead.*, vol. 24, no. 2, p. 102627, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102627>.
- [13] E. Potratz, A. Bushaw, and M. J. Weston, "Strengthening Clinical Practice Through Professional Governance," *Nurse Lead.*, vol. 23, no. 2, pp. 196–200, 2025, doi: <https://doi.org/10.1016/j.mnl.2024.11.008>.
- [14] D. L. Raab, "Integrating Clinical Research Nurses Into Professional Governance: A Structured Model for Leadership, Engagement, and Outcomes," *Nurse Lead.*, p. 102694, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102694>.
- [15] V. Rankin, R. Rose, T. Carrigan, and S. Hobbs, "The Chief Nurse Officer's Role in Transforming the Leadership Model for Patient Care Delivery," *Nurse Lead.*, vol. 23, no. 2, pp. 138–142, 2025, doi: <https://doi.org/10.1016/j.mnl.2024.10.003>.
- [16] M. Roshanzadeh, A. Jesmi, and A. Taj, "The Necessity of Using Artificial Intelligence in Developing Nursing Leadership Skills," *Nurse Lead.*, vol. 24, no. 1, p. 102578, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102578>.
- [17] C. H. Rushton, "Why Integrity Matters for Nurse Leaders: A Case Application," *Nurse Lead.*, vol. 23, no. 3, pp. 328–335, 2025, doi: <https://doi.org/10.1016/j.mnl.2024.12.014>.
- [18] A. Schmidt, "The Architecture of Resilience: Nursing Leadership for Sustainable Care Systems," *Nurse Lead.*, vol. 24, no. 2, p. 102623, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102623>.
- [19] K. M. Schroeder, "Leading Without Walls: The Evolving Role of the Ambulatory Chief Nursing Officer Across the Continuum of Care," *Nurse Lead.*, p. 102680, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102680>.
- [20] L. Spiva *et al.*, "Transforming Healthcare Teams: A Model for Success Through Nurse Manager and Clinical Nurse Leader Collaboration," *Nurse Lead.*, vol. 23, no. 5, p. 102502, 2025, doi: <https://doi.org/10.1016/j.mnl.2025.102502>.
- [21] Suprpto, "Digital Transformation and Collaborative Innovation Public Health Services in Indonesia: A Qualitative," *J. Interdiscip. Heal.*, vol. 2, no. 2, pp. 72–82, Mar. 2026, doi: <https://doi.org/10.61099/jih.v2i2.253>.
- [22] C. Volpendesta, N. Graham, E. Collins, and A. Kirchhoff, "Transforming Quality and Patient Experience in Postpandemic Nursing: A Strategic Collaboration Between System and Local Leaders Using Lewin's Change Model," *Nurse Lead.*, vol. 24, no. 1, p. 102574, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102574>.
- [23] B. Weirich, L. Martin, and A. Corbin, "Minutes That Matter: Quantifying Ambient Documentation Return on Investment in Inpatient Nursing," *Nurse Lead.*, p. 102763, 2026, doi: <https://doi.org/10.1016/j.mnl.2026.102763>.
- [24] K. Whitney and P. Tucker, "Interprofessional Leadership: Strategies for Engagement, Sustainability, and Influence," *Nurse Lead.*, vol. 24, no. 1, p. 102569, 2026, doi: <https://doi.org/10.1016/j.mnl.2025.102569>.
- [25] J. Wirkus and S. Werchek, "Advanced Practice Providers: Pursuing Transformation Through an Advanced Practice Council," *Nurse Lead.*, vol. 23, no. 3, pp. 344–348, 2025, doi: <https://doi.org/10.1016/j.mnl.2025.02.006>.