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**ACHIEVING HEALTH EQUITY:
A ROLE FOR NURSE LEADERS ON NONPROFIT BOARDS**

Submitted to the Faculty
Yale University School of Nursing

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Nursing Practice

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Abstract

Diverse board leadership plays a key role in effective local and community nonprofit organizations. Nurses with core governance competencies are uniquely positioned to serve on boards of the nonprofit organizations in the communities that they already live and work in, especially but not exclusively when those organizations focus on improving health care outcomes and advancing health promotion. While the nurse of the future is called on to lead, nurses often do not perceive themselves as being successful in governance roles. This paper describes a pilot project with the Connecticut Nurses Association (SpringBoard to Board Service) that supplemented an asynchronous online governance competencies curriculum (Best on Board) with in-person experiential learning vignettes; the pilot included an intensive, customize board match process which relied on extensive knowledge of and partnership with local and regional philanthropies and their nonprofit organization collaborators. Participant experience and readiness for board service during and after pilot was measured using the Sundeane Healthcare Index for Preparedness in Board Competency (SHIP-BC); relationships among nurse leaders and community organizations facilitated successful board match.

Keywords: Nurses on boards, governance, nursing education, board match

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Dedication

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Chapter 1: Introduction and Background

Introduction

Health is not just the absence of disease or illness but a state of complete physical, mental, and social well-being that is influenced by socioeconomic factors that shape how we live every day (Healthy People, 2020). Achieving health equity occurs when all people can attain healthy outcomes regardless of their social or economic status (RWJF, 2017). However, marginalized populations in the United States who suffer discrimination and are economically challenged continue to experience poor health outcomes. Despite a broad range of efforts to improve health for socioeconomically disadvantaged populations, there has been little progress in reducing social gaps in health and disparities (Voelker, 2008; Braveman, 2011; Braveman, 2014). There is no one-size-fits-all approach to address the health needs of marginalized populations. Addressing the complex social needs of these populations requires collaboration from multiple stakeholders in the community including from the business, education, health, insurance, nonprofit and philanthropy sectors through community partnerships (Mitchell, 2018; Tilden, 2018).

Nonprofit organizations provide services to address multiple, interrelated needs of marginalized populations such as housing, access to education, and access to gainful employment (Mitchell, 2016). Nonprofit organizations can play a vital role in building cross-sectorial partnerships between their organizations and potential partners in the community to address complex social determinants of health (SDOH) (Dendas, 2018). However, for nonprofit organizations to perform in this role, three issues regarding stakeholder representation, decision-making processes, and governance of nonprofit boards must be addressed. One, many nonprofit organizations consist of boards that are not representative of the community they serve.

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Furthermore, these boards do not actively engage with the community they aim to help. Two, regarding decision-making, board member selection is not always a transparent, democratic, or thoroughly vetted process. Rather, new board members are usually known by and invited onto a board by current members, thus perpetuating homogeneity. Three, regarding governance, nonprofit boards often do not have health care professionals serving on the boards to help influence decision-making. This is important because health care professionals often have timely, community-specific health information that can assist nonprofit organizations with better serving their communities (Mason et al, 2013). These issues, in the broadest terms, reflect areas of disconnect between nonprofit organizations and their efforts to improve health outcomes of marginalized communities.

Many nonprofit boards now recognize the need to diversify board skills, expertise, and composition to include the voice of the community at the decision-making table. Many nonprofits are incorporating diversity, equity, and inclusion (DEI) into their stakeholder, governance, and decision-making operations. While discussions regarding DEI are becoming increasingly prevalent in the nonprofit sector, the more difficult step forward is to turn the discussions into action (Kapila et al., 2016). Nonprofit commitment to DEI must be demonstrated through board leadership, governance policies, recruitment, power-sharing, and importantly, accountability to become more responsive and efficient.

One approach to address issues of stakeholder representation, decision-making, and governance with nonprofit organizations is to place nurses on nonprofit boards. Such an approach has the potential to facilitate cross-sectoral partnerships in at least three ways. First, nursing is a diverse workforce that has a long history in addressing SDOH at the community level. Nurses can bring racial, ethnic, gender, and cultural diversity to nonprofit boards. Second,

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nurses are intimately involved with the most vulnerable populations in their communities. They can serve as a voice for the health concerns of the communities they serve. Third, nurses can provide evidence-based data to assist with policy decisions that can reverse and improve health outcomes. By serving on nonprofit boards, nurses can attain leadership roles in their communities, empowering them to move beyond historical perceptions of their role as strictly caring professionals rather than leaders. To this end, this project seeks to identify ways to facilitate the entry and placement of nurses on nonprofit boards as part of building cross-sectoral partnerships between nonprofit organizations and the marginalized communities they serve.

Background

Health equity is the principle underlying the commitment to reduce and ultimately eliminate disparities in health and its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of marginalized populations (Braveman, 2014). Healthy People 2020, an initiative of US Department of Health and Human Services, defined health disparity as a health difference linked to economic, social, environmental disadvantages (Healthy People, 2020). Namely, poor health is frequently the outcome for people who are discriminated against due to race, ethnicity, religious, socioeconomic status, gender, age and mental or physical disabilities (Braveman, 2014; Farrer, 2015). Social determinants of health (SDOH) are the social, economic, and environmental circumstances in that people are born into, and experience in daily life and work which are influenced by economic policies, the distribution of power, and resource allocation (Healthy People, 2020). The World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) in 2008, called for “closing of health gap in a generation” by improving the conditions of daily life; tackling the equitable distribution of power, money,

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and resources; measuring and evaluating the problem; and increasing public awareness (Farrer, 2015).

Marginalized populations are those populations that have suffered discrimination, inadequate access to key opportunities, and are socially and/or poor. These would include populations such as indigenous people, people of color, people living in poverty, physically or mentally disabled people, LGBTQIA persons, women, refugees, incarcerated people, and veterans (RWJF, 2017). To achieve health equity, actions and strategies are needed to remove barriers and increase opportunities for them to be as healthy as possible. There is no one-size-fits-all approach to address their complex needs. Rather, collaboration from multiple stakeholders in the community from the business, education, health, insurance, nonprofit and philanthropy sectors through community partnerships will be more effective (Mitchell, 2018; Tilden, 2018).

While external collaboration among multiple stakeholders may be a critical objective for achieving health equity, the structure of internal relationships between partners is just as critical. To this point, it is important to examine power relationships between nonprofit boards and the communities they serve. Block and Rosenberg (2002) mention that class structures often exist within nonprofit boards. Board members may be conferred status from years of service, significant financial donations, and personal, or professional standing in the community (Block & Rosenberg, 2002). While Block & Rosenberg (2002) acknowledge that board members may use positions of influence, power, and privilege to accomplish the goals of the organizations, these advantages may interfere with the organization's delegation of control. Issues of control may surface as power struggles for community members to have a meaningful voice in the

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decision-making processes about funding, governance, and other matters related to their communities.

Nonprofit organizations are considering ways to work more authentically with communities and beginning to see the internal work needed to confront internal imbalances in power and systems of oppression to influence the root causes of health inequity—systemic racism and poverty (Farhang, 2018). The need to address oppressive systems and health inequity has only been highlighted by recent events- George Floyd and COVID-19. As on-the-ground professionals in their communities, nurses can make meaningful contributions in positions on nonprofit boards by bringing their knowledge of SDOH to nonprofit boards and helping to align the organization’s internal governance initiatives with its mission. What follows highlights information on institutional and organizational efforts to prepare nurses for leadership positions and efforts to place nurses on boards to participate in policy decision-making.

In 2010, to improve the health of the nation and promote board governance as an extension of nurse leadership, the Institute of Medicine (IOM) issued *The Future of Nursing: Leading Change, Advancing Health*, a report arguing that to transform the health care system and the nursing profession, nurses need to be full partners at decision-making tables (Institute of Medicine, 2010). The report challenges nurses to design models of care that address SDOH they have encountered while providing care to patients and clients in tertiary facilities, primary care agencies, and in the community. It also states that nurses should serve actively on boards where policy decisions are made to improve health systems (Drenkard, 2015; Hassmiller, 2013; Hassmiller & Reinhard, 2015; Persaud, 2018; Sundean, 2017; Sundean et al. 2017). In the same year, the Robert Wood Johnson Foundation (RWJF), in partnership with AARP, launched a “Campaign for Action” to implement recommendations made in the IOM *Future of Nursing*

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report. RWJF has also spent millions promoting the “Culture of Health Action” initiative to address SDOH (Polansky et al., 2017). The “Culture of Health Action” Framework identifies action areas for driving measurable sustainable progress and improving the health of all people. It includes making health a shared value and participating in activities that advance the public good and help communities thrive through initiatives including cross sector collaboration; creating more equitable, inclusive communities by improving social conditions; and strengthening the integration of healthcare, public health, and social services (RWJF, 2019).

Nurses can promote a culture of health and improve the health of their communities through board service. The national Nurses on Board Coalition (NOBC) supports nurses examining organizations and whether they align with SDOH (Benson, 2017). When using this lens, organizations that appear to be outside of traditional healthcare often align well with nurses who can use their expertise to have an impact and influence the health of their community through board service.

There is no consensus yet on the optimal way to prepare nurses for board governance roles (Hill, 2008; Hassmiller, 2012; Hassmiller & Combs, 2012; Lathrop, 2013; Westphal, 2014; Walton, 2015; Curran, 2016; Staler, 2016; Salmon, 2016; Sundean et al., 2017; McCollum et al., 2017; Cadmus, et al., 2018; Sundean et al., 2019). While there is literature on preparing nurses for service on healthcare boards (Curran, 2016; Sundean et al., 2019; AHA, 2020), there is no evidence on how to best prepare nurses for nonprofit board service. There is, however, emerging research that provides compelling evidence for the value added by having nurses serving on healthcare governing boards (Harper & Benson, 2019; Sundean et al., 2019; & Szekendi, et al., 2015). To date, there is no literature on the effects of nurse leaders serving on nonprofit boards.

Problem Statement

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When we adopt an SDOH lens, health is more than just access to healthcare. It involves addressing the root causes of poor health, including the social, economic, educational, and environmental inequities that create health disparities in marginalized communities. Notably, both nurses and nonprofit organizations are key providers of critical quality of life services in marginalized communities. For the most part, these actors function independently. To meet the complex needs of the communities they serve; these entities must be strategically allied in ways that advance health equity. Nonprofit board service provides one venue for nurses to leverage their status as the “most trusted” professionals (Gallup, 2020), culturally and socially competent caretakers, and effective problem solvers for the communities they serve. Despite this recognition, nurses are severely underrepresented on nonprofit boards. There are over 3 million nurses in the US yet only 2% of nurses serve on nonprofit boards and 5% on healthcare boards (Sundean, 2018). There is a need not only to prepare nurses as leaders for effective board service, but to connect them with the nonprofit boards which seek their input. This project seeks to address this problem by identifying ways to facilitate the entry and placement of nurses on nonprofit boards as part of building cross-sectoral partnerships between nonprofit organizations and the marginalized communities they serve.

Definition of Terms

501(c)(3) organization: A corporation, trust or other type of charitable organization that is exempt from federal income tax under section 501(c)(3) of Title 26 of the US Code.

Board: Fiduciary body made up of members whose responsibilities include steering an organization toward a sustainable future by adopting sound ethical, legal governance and financial management. The role of a nonprofit board is to oversee the organization on behalf of others. It involves stewardship of assets and resources, mission, community trust and

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organization's reputation (Sundean et al., 2017). The NOBC defines a board as a decision making-making body with strategic influence to improve the health of communities nationwide. This includes corporate, governmental, nonprofit, advisory or governance boards, commissions, panels, or task forces that have fiduciary or strategic responsibilities (NOBC, 2018).

Competencies: A combination of knowledge, skills, personal characteristics, and behaviors needed to perform a job or task effectively (Curran & Totten, 2010).

Downstream: "Interventions and strategies focus on providing equitable access to care and services to mitigate the negative impacts of disadvantage on health" (NCCDH, 2020).

Diversity, Equity, and Inclusion (DEI):

- **Diversity** includes ways in which people are different and references the following:

race, ethnicity, gender, age, national origin, religion, disability, sexual orientation, socioeconomic status, education, and marital status.

- **Equity** is the fair treatment, access, opportunity, and advancement for all people while striving to eliminate barriers that prevent the full participation of some groups.

- **Inclusion** is the act of creating environments in which any individual or group can be and feel welcomed, respected, supported, and valued to fully participate (Teitsworth, 2018).

Board governance: Ensures that an organization operates responsibly and ethically. Promote prudence, accountability, transparency, and diversity. Conduct routine performance assessments to evaluate internal and external effectiveness (Curran, 2016).

Health: Defined in the 1948 Constitution of World Health Organization (WHO), as "a state of complete physical, mental, and social well-being and not just the absence of disease or illness" (Healthy People 2020).

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Health disparity: Preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (Kaiser Family Foundation, 2018).

Health equity A measure in which people can attain their health potential and no one is disadvantaged from achieving this potential because of their social or economic status (Healthy People, 2020).

Health philanthropy: Addresses health disparities along an “upstream” and “downstream” continuum. This includes supporting “upstream” strategies such as improving housing, increasing access to education and gainful employment, alongside continued “downstream” work such as improving access to safe, affordable, and quality health care (Mitchell, 2016).

Marginalized populations: Populations that have suffered discrimination, inadequate access to key opportunities and/or are socially and or poor. This includes people of color, people living in poverty, physically or mentally disabled people, LGBTQIA+ persons, women, refugees, incarcerated people, and veterans (Robert Wood Johnson Foundation [RWJF], 2017).

Nonprofit: Nonprofit and not-for-profit are often used interchangeably and indicates an organization established for purposes other than profit making and is recognized by the government as tax exempt.

Nonprofit organizations: Provide services and grants in a wide variety of areas that are of importance to the community, including supporting hospitals, educational institutions, museums, and organizations dedicated to assisting those in need. The mission of a nonprofit organization sets forth the purpose for which the organization was formed and granted special legal nonprofit status 501(c)(3). This mission drives the activities carried out by the organization.

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The board is responsible for governing the nonprofit to carry out this mission. The assets of a not-for-profit organization are intended to benefit the public good and are restricted by law toward that use alone and cannot be used outside the charitable objective for which it is intended to serve (Curran, 2015).

Nonprofit Stakeholders: Those significantly affected by the organization and interested that it fulfills its mission. They can be either individuals or groups who have needs that they rely on an organization to meet. They are invested in a way other than monetarily (Curran, 2015).

Philanthropy: the promotion of well-being by solving or preventing social problems.

Public foundations: Often referred to as charities, public foundations are nonprofit organizations that rely on donations from individuals, the government, corporations, and private foundations to fund their operations and programs.

Social Determinants of Health (SDOH): The conditions in which people are born, grow, live, work and age. They include factors like socioeconomic status, education, neighborhood and physical environment, employment, and social support networks as well as access to care and health information (Mitchell, 2016).

Upstream: “Interventions and strategies focus on improving fundamental social and economic structures in order to decrease barriers and improve supports that allow people to achieve their full health potential” (NCCDH, 2020).

Chapter 2: Literature Review

Health Equity

Health equity is the principle underlying the commitment to reduce and ultimately eliminate disparities in health and its determinants, including social determinants. It is now recognized that healthcare access (i.e., “downstream”) only accounts for 20% of health outcomes while the SDOH such as employment and educational opportunities as well as the physical environment including access to reliable transportation, safe and affordable housing, and nutritious food and clean water (i.e., “upstream”) account for 80% of health outcomes (Bambra et al., 2010; Farrer et al., 2015; Kneipp et al., 2018). Scientists specializing in SDOH, policymakers, grant-makers, foundations, private and public healthcare organizations, have all attempted to change the healthcare system in one form or another. However, there continues to be insufficient collaboration between health and other sectors that has resulted in policy and funding silos (Braveman, 2014; Kneipp, 2018).

The empirical literature about SDOH reflects decades of studies that have linked adverse social, economic, and environmental conditions with poor health (Voelker, 2008; Anderson, 2012; Braveman, 2014; Artiga & Hinton, 2018; Knighton, 2018). The literature that describes efficacious interventions to address SDOH is less developed but essential to generating evidence-based approaches to create positive effects on health (Amaro, 2014; Evans-Agnew et al., 2017; Abbott & Elliot, 2017). This abyss has slowed health policy making and the promotion of innovative models of care (Braveman, 2014). Two major changes in the past decade that address SDOH are discussed in the following sections.

The Affordable Care Act (ACA) of 2010 provided a key opportunity to help improve access to care and reduce disparities faced by marginalized populations through both its coverage

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expansions and increased awareness of the need to address SDOH, there are emerging initiatives that address SDOH and focus on health in non-health sectors. One approach, “Health in all Policies,” is an approach proposed in the final report by WHO’s Commission on SDOH in 2008 that incorporates health considerations into decision-making across sectors, and policy focused on place-based initiatives (American Public Health Association, 2013). Place-based strategies seek to strengthen the physical, social, structural, and economic conditions that affect the well-being of a community while keeping costs down (KFF, 2018). The ACA also requires all nonprofit hospitals to complete Community Health Needs Assessments (CHNAs) every three years to develop strategies to address community identified needs (Amaro, 2014; Evan-Agnew et al., 2016).

Another powerful lever to engage the healthcare system in addressing SDOH has been payers moving toward Value-Based Payment (VBP) models. The traditional Fee-For-Service (FFS) reimbursement model rewards volume-based approaches to care that emphasize diagnosis and treatment. The FFS payment model does not adequately reimburse for care outside of the healthcare system, which contributes to care being episodic and illness focused. Conversely, VBP models promote community wellness and incentivize active engagement between healthcare organizations and the external community at a population level (Lipstein & Kellermann, 2016; Knighton et al., 2018). Incorporated in this model is the active engagement between care delivery and care management as well as a focus on keeping the patient healthy. The reasoning is that people in good health are more involved in their care and use less health services which has a substantial downstream effect on health care spending.

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i. The Nonprofit Sector

The nonprofit sector provides essential services and is well positioned to serve various roles in the community (Beccaria, 2016). Nonprofit organizations play a vital role in building healthy communities by providing critical services in our society. In the US, the nonprofit sector accounts for 9% of GDP and employs 11% of workforce (Board Source, 2017). In any given community, there are three key players. There are: community-based organizations that deliver programs and services addressing SDOH. Philanthropy includes volunteers and grant makers to these organization, and government agencies who make these critical services available (Easterling & McDuffee, 2018). There are several types of nonprofit organizations providing essential services and addressing issues such as protecting the environment, food insecurity, housing, safety, education, health, employment, and religion. Combined, these organizations serve people of every age, gender, race, and socioeconomic status. Nonprofit revenue comes from government funding, fees for services rendered, and donations from individuals, foundations, and corporations. Because nonprofit organizations provide vital social services to the public and help the government meet the public's needs, they receive tax exempt status and are referred to as 501(c)(3) organizations. The terms "nonprofit" and "tax exempt" are often used interchangeably. The IRS tax code distinguishes nearly three dozen forms of tax-exempt organization. Each type must meet certain conditions to be exempt from paying federal income taxes. One common condition is that nonprofits do not pay out profits, and any profit generated by the organization must be used to promote the organization mission and meet the needs of their mission-defined stakeholders.

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ii. Role of Philanthropy in Nonprofit sector

Philanthropy plays a critical role in the community. While grantmaking individuals and bodies vary widely in the philanthropy arena, this discussion will focus specifically on the role of community foundations and conversion foundations because they are well seated in the community to address health equity and connect nurses to nonprofits in their communities.

Conversion Foundations

Perhaps the most profound change in health philanthropy in the past 25 years is the emergence of health care conversion foundations, which are formed when nonprofit health institutions are acquired by for profit businesses, or otherwise converted to for profit status. The proceeds of these transactions are transferred into an endowment whose mission is to improve the health of their communities. According to Grantmakers in Health, by 2018 there were at least 242 conversion foundations in the US (Easterling & McDuffee, 2018). Most of the philanthropic work addressing SDOH originated in health conversion foundations.

Community Foundations

Community foundations are grant making public charities that facilitate and pool donations including from private and corporate foundations to support local nonprofits in their communities (Board Source, 2017). They raise funds from individuals as well as private foundations and play a key role in identifying and solving community problems (Sacks, 2014). Community foundations conduct other activities in addition to grant making. As experts on the local nonprofit infrastructure and on community needs, community foundations can use their convening and connecting power to bring together grantees, nonprofits, and community leaders. By engaging diverse stakeholders, they can bring community members who typically would not be at the decision-making table and involve those who are affected by health inequity in

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designing and implementing solutions (Doykos, 2016; Mitchell, 2018). It is this precise ability that makes community foundations best suited for facilitating connections between nurses and nonprofit boards in their communities.

Effective Board Governance and the Need for Diversity, Equity, and Inclusion (DEI)

Many nonprofits struggle to meet the needs of their constituents and need more effective board governance. Nonprofits are looking for board members who will be actively involved in promoting and supporting their missions. Board governance is the oversight and management of an organization to ensure that it is operating responsibly and ethically and in the best interest of stakeholders (Murt, 2019; Vestal, 2015). Nonprofit board members have the fiduciary responsibility to act as stewards of the organization mission and act in the best interest of the stakeholders: the public at large or designated individuals within that group. The time, talent, and connections that community leaders volunteer is critical to nonprofit organization performance.

Due to the retirement of baby boomers and the changing ethnic and racial makeup of the US population, nonprofits face serious, growing challenges that can limit their ability to serve the people and communities that rely on them. Many boards are patriarchal in composition if not by nature. Most board members are wealthy, older white males with fiancé and legal expertise who often do not represent the communities they serve. To become more diversified, nonprofit boards should include community members from many different backgrounds, areas of expertise, and skills to effectively function and shift the power dynamic and bring new voices to the table (Ramakrishnan, 2012; Zaichkowsky, 2014; Vestal, 2015; Gould, 2018). By making a shift to include women, and members from diverse ethnic and racial groups, boards will better reflect their stated values for diversity, equity, and inclusion (Teitsworth, 2018).

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Nonprofits have also identified the following areas as needing improvement: fundraising; communication and marketing; program evaluation; performance management; technology; and strategic planning. Other areas for strengthening include board governance, human resource management and financial planning. Evidence suggests that organizations with more women have more board member engagement in oversight and governance, fundraising and advocacy, all of which affect the board's ability to help an organization achieve its goals (Osili, et al. 2018). There is also a need to democratize access to board service. While board membership is often conferred through personal invitation by a sitting board member, most nonprofits lack a formal board selection process that is open and accessible to the public.

An Opportunity for Board Governance for Nurses

Board composition is critical to effective board governance. Engaging nurses in board governance can impact board performance and improve the functioning of nonprofit boards. This in turn will lead to more effective delivery of nonprofit services to their communities, thus improving health in their communities (Huff, 2014; Prybil et al., 2014; Szekendi, 2015; Benson, 2019; & Sundean, 2019; Murt, 2019).

Nurses often serve on their professional organization boards and on various committees within the health care setting, thus demonstrating governance abilities such as strategic visioning and organizational decision-making. They are often the most knowledgeable health care professionals on issues of quality, safety, and strategic planning (Harper & Benson, 2019; Huff, 2014; Prybil et al., 2014; Szekendi, 2015; Murt, 2019). On the merits of their knowledge and skills, nurses are also often qualified to serve on boards outside of the healthcare system. However, nurses refrain from serving on nonprofit boards because they believe they lack the financial capacity to donate funds and have a narrow view

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of philanthropy as wealthy people donating money. This perspective grossly undervalues the importance of the time, talent, and connections that they can offer as community leaders to a nonprofit organization and their contributions to nonprofit organization performance (Sundean, 2017).

Because nurses have both knowledge of the health care system and intimate knowledge of the communities they serve, they can be a voice for their community. Nurses are part of a large and diverse workforce. Of the over 4 million registered nurses working in the U.S. in 2019, 90.4% are women and 26.7% are minorities. (U.S. DHHS, HRSA, 2019). Unlike other healthcare professionals, nurses can be a voice for their community because most nurses live in the communities where they work, often residing and working within 40 miles of where they have grown up (Spetz, 2015). However, despite living in the communities they serve, nurses report lacking connections to community organizations that facilitate recognition for board service. To overcome this issue, Salmon (2016) recommends that nurse's network and forge relationships in their community by volunteering for committee work including: fundraising, advisory, governance and strategic planning committees.

As the nation's most trusted professionals (Brenan, 2018; Nurses.org, 2020), nurses also make excellent fiduciaries. Fiduciaries steer an organization toward a sustainable future by adopting sound ethical, legal, governance, and financial management. The role of the nonprofit board is to oversee the organization on behalf of the public it serves (Sundean et al., 2017). Nurses are also relationship-focused and skilled in consensus building, patient advocacy, team building, and multidisciplinary collaboration which makes them natural stewards for any organization they serve (Hassmiller, 2013; Harper & Benson, 2019).

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Serving on health philanthropy and nonprofit boards offers nurses a unique opportunity to address SDOH and improve health equity. It is also an effective way for nurses to build business skills, expand work experience, network, and boost the public profile of the nursing profession. In summary, nurses are well suited to serve as partners with other non-healthcare professionals and be recognized for their contributions (Hassmiller, 2013; Benson, 2017; Prybil et.al. 2019).

Preparing Nurses for Board Service

The 2010 Institute of Medicine (IOM) Future of Nursing report recommended that healthcare decision makers ensure that leadership positions be filled by nurses. Healthcare decisions are not made exclusively within hospital boardrooms; they also include the contributions of community-based, nonhealthcare boards. However, some nurses may lack the knowledge, experience, or confidence for successful service as a board member (Groysberg & Bell, 2013). Feeling unprepared for board governance is a common sentiment among nurses because they are not formally educated about governance and do not recognize governance leadership as part of their professional nurse identity (Sundean, 2019). The NOBC provides digital toolkits, as well as videos, presentations, brochures, webinars, and articles created by national nurse leaders to enhance nurses' understanding of the skills needed to serve in board rooms.

For nurses, understanding roles and responsibilities of nonprofit board members is critical to effective governance and becoming involved in this important sector of society. These activities link effective board and organizational performance to competency-based governance (Prybil et al., 2013). Competencies are the combination of knowledge, skill, personal characteristics, and behavior needed to perform a job or task effectively (Curran &

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Totten, 2010). Basic board competencies include fiduciary and stewardship responsibilities, mission driven strategic planning, quality, and safety, financial, CEO and board relationship and effective governance (Curran, 2016).

Much of the literature focused on basic board competencies is geared toward healthcare boards (Hassmiller, 2012; Curran, 2016; Stalter, 2016; Prybil et al., 2019). Responding to the need for effective governance, the American Hospital Association (AHA) developed Core Governance Competencies focused on hospitals. These competencies can also be applied to the public and private sectors (Sundean, 2019).

The AHA course, “Best on Board” is an online education, testing, and certification program concurrent and prospective board members. The certification is valid for three years (Curran & Totten, 2010; Walton, et al., 2014). This course, which covers basic board competencies, can be applied to all boards, and includes fiduciary and stewardship responsibilities; mission-driven strategic planning; quality and safety; financial; CEO and board relationship and effective governance (Curran, 2016). Nurses who serve on boards felt that standardized orientation experience was often missing and would be beneficial (Walton, 2015). There is a difference of opinion on how best to prepare nurses for board positions. Governing boards vary widely across industry, sectors, culture, and organizational purpose. Salmon (2016) contends that nursing education alone cannot prepare nurses for board roles, and there is a need for cross-disciplinary preparation to be effective board members. Westphal (2014) suggests that nurse education and skills can be developed within nursing through professional practice, committee work, professional organization engagement, formal and informal education programs, and community organization participation. Sundean et al. (2019) describe a strategy for including governance content in nursing

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education by leveraging the similarities between the AHA Core Governance Competencies and the Massachusetts Nurse of the Future Core Competencies.

A systematic review of the literature by Sundean et al. (2017) showed the need for more research to substantiate governance leadership for nurses and a need for nurses to be proactive in gaining board appointments to fill in research gaps. However, Szekendi et al. (2015) found that nurse representation on a board was associated with high performing hospital boards. Nurses need to expand into the community and engage in board service to forge relationships with nonprofit organizations to find mentors and hone skills that make them valuable on boards and in their communities (Hassmiller, 2013; Lathrop, 2013; & Westphal, 2014; McCollum, 2017; Cadmus et al., 2018). A significant obstacle to this expansion, though, is that nurses often lack connections that lead to board appointments (Prybil et. al., 2014). Nurses have the education, skill sets, and unique holistic perspectives of providers, patients, families, and communities to make a significant impact serving on nonprofit boards that address health equity (Persuad, 2018).

Synthesis

Only a multiplier force of united partners can reduce the health consequences of adverse SDOH in marginalized communities. Achieving health equity also requires organizations to change their internal governance structures to embrace community voice and diversity. Through collaborations with other professionals and community partners, nurses can assume a leadership role in addressing the social factors that influence health of the nation as well as advance the nursing profession. There is much work to be done by nurses to forge community relationships and network to be appointed to board positions on non-healthcare boards. Serving on nonprofit boards offers nurse leaders a powerful vehicle to influence change, collaborate with other

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community partners and to make impactful change and improve health equity. For nurses to develop the knowledge and skills required to function effectively on boards, a system is needed for training and promoting nonprofit board service. The development of an educational program that addresses specific board competencies and a process to connect nurses with boards based on their skill sets, passions and goals is necessary to address existing gaps in advancing nurses in these roles.

Conceptual Framework

According to Albert Bandura, self-efficacy, which refers to an individual's belief in his or her capacity to execute behaviors necessary to achieve goals, influences thought patterns, actions, and emotional arousal (Bandura, 1977). The higher the level of induced self-efficacy, the higher the performance accomplishments and the lower the emotional arousal (Bandura, 1981). Self-efficacy has considerable functional value. It influences choice of activities and environmental settings. It also influences how much effort people will expend toward goal attainment and how long they will persist when faced with obstacles. Self-efficacy is not a trait that some have, and others do not. Everyone can exercise and strengthen his or her self-efficacy.

Bandura presents four ways to build self-efficacy: Mastery, Social Modeling, Social Persuasion and Physiological, and Emotional State. Bandura (1981) posits that the key to Mastery is approaching life with dedicated effort and experimenting with realistic but challenging goals. Successes raise mastery expectations, while repeated failures lower them. Experiencing failure is important to building resilience (Bandura, 1981). Social Modeling generates expectations in observers that they can improve their own performance by learning from what they have observed as demonstrated by a chosen role model with whom they can identify (Bandura, 1981). Coaching and giving evaluative feedback on performance are common

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forms of Social Persuasion. Finding the right mentor who can role model and create strengthening experiences is essential (Bandura, 1981). Physiological and Emotional State can influence our interpretation of self-efficacy. By learning how to manage our emotions and deal with them, we become less susceptible to reacting to them. This relates to the concept of emotional intelligence (Bandura, 1981). Figure 1 shows a conceptual model which unites Bandura's (1981) four ways to build self-efficacy. In closing, by employing self-efficacy, individuals can choose activities and environments best suited to their growth and development. Through the mastery of thoughts, motivations, emotions, and decisions with the guidance and modeling by a role model, individuals can strengthen performance and successfully achieve goals.



Figure 1. Bandura's (1981) Conceptual Model of Self-efficacy: Four Sources of Efficacy Beliefs. Source: Self-Efficacy by Albert Bandura (2017)

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Bandura's four sources of self-efficacy served as a conceptual framework for this project, which was to develop an educational program to prepare nurse leaders for effective board service. The challenge was not only about educating nurses but also getting nurses to consider board service (Sundean et al., 2018). Many nurses do not consider board service because they believe they lack the competencies to act in these roles (Hassmiller & Reinhard, 2015; Benson, 2017). This model focused on interventions that enable nurses to develop self-efficacy. Through experiential learning and mentorship, nurse would become more confident in their ability to serve on boards and would develop core competencies to be effective board members.

Environmental Scan

In 2010, RWJF partnered with the Institute of Medicine (IOM), now the Academy of Sciences, Engineering, and Medicine, to produce the landmark *The Future of Nursing* (FON) report that set a vision for nursing in 2020. The committee, under the leadership of Dr. Donna Shalala, produced a set of recommendations and provided a blueprint for improving nurse education; ensuring that nurses can practice to the full extent of their education and training; providing opportunities for nurses to assume leadership positions; and improving data collection for policymaking and workforce planning.

In 2010, RWJF also partnered with AARP and created the Center to Champion Nursing in America (CCNA). The CCNA was created to put *The Future of Nursing* report into action. Housed in the AARP Public Policy Institute (PPI), the CCNA coordinates the "Future of Nursing: Campaign for Action," a national effort to improve America's health through nursing. The report advanced the position that nurses need to be at decision-making tables to design care that addresses SDOH faced by marginalized populations. There are action coalitions in every state to carry out the work of the Campaign at the local, regional, and state level, including

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representatives from health, business, education, and other areas working to build healthier communities through nursing. Since 2015, the Campaign has increasingly tied its work to the Culture of Health vision inspired by RWJF, which, echoes a tenet of nursing: everyone deserves to live the healthiest life possible.

In 2014, the nonprofit NOBC was convened and set the goal of having 10,000 nurses on boards by 2020, designated the International Year of the Nurse and the Midwife by the World Health Assembly (Benson, 2017; Hassmiller & Reinhard, 2015). As of February 2021, the NOBC reported 10,067 nurses currently serving on boards outside the profession and extending into the communities ([NOBC, 2020](#)).

In 2019, a new committee was announced under the auspices of the National Academies of Sciences, Engineering, and Medicine that will extend the vision for the nursing profession into 2030 and chart a path for the nursing profession to help create a culture of health, reduce health disparities, and improve the health and well-being of the US population in the 21st century. The committee will examine the lessons learned from the Future of Nursing: Campaign for Action, as well as the current state of science and technology, to inform their assessment of the capacity of the profession to meet the anticipated health and social care demands from 2020 to 2030. RWJF, though continuing its support of nursing, will now be focusing on the Culture of Health initiative and will encourage nurses to demonstrate how they are impacting health in their communities and addressing SDOH. Nurses, unlike many other healthcare providers, serve in many settings throughout the health care continuum and are uniquely positioned to serve a leading role in implementing RWJF's vision for a Culture of Health.

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This project relied heavily on the potential success of partnerships within and beyond the professional and academic nursing communities and benefited particularly from alliances with state and local philanthropies and nonprofits. These partners are described here:

i. Professional Nursing Partners

In addition to the NOBC and RWJF, the American Nurses Association (ANA), the professional organization to advance and protect nursing, through their philanthropic arm, the American Nurse Foundations (ANF) is a founding member of the NOBC and dedicated to advancing nurse leadership. Locally, the Connecticut Nurses Association (CNA) exerts its influence on education, legislation, and compensation to protect and advance the practice of nursing and the health of people in Connecticut. CNA is the NOBC representative in Connecticut and is continuing the work of the Connecticut Nursing Collaborative-Action Coalition to promote the Culture of Health initiative. The CNA surveyed their membership and identified a need for a board competency educational program. This project reflects those needs and a partnership with the CNA was facilitated to pilot an educational program that prepares nurses for boards.

ii. Potential Philanthropic Partners

Historically, nonprofit and philanthropic boards have been patriarchal in nature. With an eye to improving reach and efficacy, they are now changing to become more transparent and diverse. Because there are currently often no healthcare professionals at these decision-making tables, there is an opportunity for nurses to make an impact. This requires nurses to forge relationships with local nonprofits within their local communities; translate their nursing skills into skills that will be beneficial to board service; and find mentors. Philanthropic and nonprofit boards have their own unique characteristics, but all share the need for stewardship and

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governance. Health care philanthropy, in response to changes brought about by the Affordable Care Act (ACA), also shifted its focus from interventions aimed at downstream effects such as heart disease, stroke, cancer, diabetes, respiratory conditions, and obesity, to include interventions in upstream factors, such as the socioeconomic and physical environments that cause disparities in health. Throughout the State of Connecticut there are hundreds of nonprofits seeking to enhance the quality of life in their communities and improve the lives of their neighbors and constituents. There is no statewide effort to connect volunteers with these organizations. The following are examples of Connecticut organizations who maintain partnerships critical to connecting nurses to nonprofits in their communities, and which leverage community engagement to create change.

- **Social Venture Partners Connecticut (SVP-CT):** SVP-CT is a local community of philanthropic partners leveraging their time, expertise, and resources for sustainable solutions to problems, while becoming strategic and effective in personal giving. SVP-CT works with innovative organizations whose mission is to narrow the opportunity gap in Connecticut. SVP-CT is part of SVP, a global philanthropic network of partners working in their communities. SVP-CT is a member organization at the following:
- **Fairfield County Community Foundation (FCCF):** FCCF is a public charity that helps individuals and organizations improve their communities through philanthropy (FCCF, 2020).
- **The Connecticut Council for Philanthropy (CCP):** CCP is a nonprofit association of grant makers committed to promoting and supporting effective philanthropy for the public good in Connecticut (CCP,2020).

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- **Community Foundations of Connecticut:** Community foundations are grant making public charities that improve the lives of people in their geographic area. There are 21 community foundations serving the entire state of Connecticut (CCP, 2020).
- **Leadership Greater Hartford:** Believes leadership is bringing people of diverse backgrounds together to build awareness and mutual trust needed to create constructive partnerships that serve the greater good (Leadership Greater Hartford, 2020). They have a Leaders on Board program targeted to middle- and late-career professionals, and retirees. Leaders on Board helps nonprofits find new members who bring their diverse perspectives, skills, and experiences to the important work of their organizations.

Gap Analysis

Though there is currently a big push in philanthropy and the nonprofit sector to support diversity, equity, and inclusion, many of these organizations do not have a formal channel to connect community members with diverse skill sets to meet the unique needs of each nonprofit. Only one program in Connecticut was identified that trains and matches volunteers to serve on non-profit boards: Leaders on Board, a program of Leadership Greater Hartford. Leaders on Board is a very effective way of connecting community volunteers with diverse skill sets and backgrounds to organizations looking for board members in the Greater Hartford area and has some reach across the state.

The Leaders on Board process is like Board Match, a national 501(3)(c) organization supported by Google and Ascent, currently serving major cities like San Francisco, Palo Alto, New York, and Washington DC. They are not currently in Connecticut. Board Match was contacted to discuss plans for expansion into the Connecticut area. While doing so is among their long-term goals, it is not in their near-term plans. Leadership Hartford operated through the

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United Way and funded primarily through the Hartford Foundation for Public Giving. Leaders on Board is offered as a free service to volunteers seeking board service. Nonprofits pay a sliding scale fee to attend the match sessions. The Leaders on Board model is a simple process that involves attending one meeting to meet the Leadership Hartford team along with other members in the community who are also seeking board service, followed by attendance at a board match session. The initial meetings are scheduled monthly and intended as a primer for participants in board governance and nonprofit organizational structure. The Express Matches are scheduled according to interest and need but are usually held monthly. Express Match events take the “speed dating” job fair format to match potential community volunteers with nonprofit organizations actively looking for board members. It has been shown to be an effective way of connecting community volunteers with diverse skill sets and backgrounds to organizations looking for board members in the Greater Hartford area.

Fairfield County Community Foundation (FCCF) was the only community foundation identified that was interested in developing a matching program like the Leader on Board program, through their Center for Nonprofit Excellence. The matching process will be initiated sometime in 2021. Few community foundations have the financial capacity or resources to fund such a program.

As mentioned earlier, there is great need to democratize access to board service. As a result of this project, the Connecticut Council of Philanthropy has invited me to consult on how to improve DEI representation and share my recent experience with the SpringBoard to Board Service initiative. There is a greater need for more nurses with expertise in philanthropy and board service work to provide education and consultation to various types

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of non-profit and philanthropic organizations in order to diversify their boards and/or provide health specific guidance.

Leadership Immersion

Relationship building was both a means and an end to the success of this pilot program. To ensure meaningful opportunities for board participation, successful board match and leadership, the following steps were taken: 1) author forged relationships with multiple partners to connect nurses to nonprofits in their communities, 2) and was required to network, develop marketing materials, and pitch the idea to many stakeholders.

i. Relationship building with Nursing

A partnership was formed with Dr. Cynthia Holle, Vice President, and Kimberly Sandor, Executive Director, on the Connecticut Nurses Association (CNA) SpringBoard to Board Service pilot program. The CNA approved the use of residual funds from the Connecticut Nursing Collaborative-Action Coalition, a grant from the Robert Wood Johnson Foundation's national Culture of Health initiative, to pilot this program. Dr. Holle had previously collaborated with Best on Board (BoB), a healthcare governance education organization administered by the Montana Health Network to use their BoB's Essentials of Healthcare Governance online learning curriculum based on Connie Curran's book, *Nurse on Board: Planning your Path to the Board*. The on-line course provides a foundation of common knowledge about what is required to lead healthcare organizations and strengthens participants' ability to serve on any board. Dr. Holle graciously agreed for me to partner with her on this endeavor. It was agreed that the following would be accomplished:

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1. Develop onsite board simulation and learning activities which track with, complement, and enhance BoB on-line learning modules.
2. Forge relationships with philanthropy and the nonprofit sector to connect nurses to nonprofit board service.
3. Solicit funding for nurse participant scholarships.
4. Perform an individualized board match service for any participant who was interested.
5. Lead on the Holle Board Search Workbook, a roadmap for participants seeking to connect with boards.
6. Evaluate the pilot with the SpringBoard team to make recommendations to the CNA board of Directors for future programs.

ii. Relationship Building with Philanthropy and the Nonprofit Sector

Relationships were also developed with Leadership Greater Hartford, three community foundations, Connecticut Council of Philanthropy and Connecticut Health Foundation.

- **Leadership Greater Hartford**

A relationship was developed with Mae Maloney and participated in Leadership Greater Hartford's Leader on Board program. The author attended a board match event and was the event attendee who successfully matched with the most nonprofits. There were many opportunities to help nonprofits, including by serving on advisory boards and fundraising committees. Most nonprofits were seeking content expertise and needed active and engaged board members to support the CEO with strategic planning and fundraising. Opportunities were concentrated in the Metro Hartford area with limited state reach. Leadership Greater Hartford and CNA were

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connected by the author to discuss a partnership going forward on this initiative. Sharing their Leader on Board model with other community foundations throughout the state is also a priority, but one which is limited by funding sources.

- **Community Foundations**

Community foundations were identified as a potential conduit to nonprofit board service because of their deep connections within and knowledge about their community's needs, which span areas including education, economic development, arts and culture, health, and human services. As major local grant-makers, leaders of community foundations have intimate knowledge of the various nonprofit organizations in their communities and are poised to critically evaluate the effectiveness of an organization and its governance in grantmaking. They also are aware of which organizations are looking for board members. As key funders, they can garner nonprofit buy-in to the concept of nurses serving as board members.

Through partnerships with Social Venture Partners (SVP-CT) and through service on their investment committee, a relationship was forged with Karen Brown, Vice President of Development and Philanthropic Services at Fairfield County Community Foundation (FCCF). Ms. Brown was instrumental to the success of the program. Brown fully supported this initiative and agreed to help place nurses in the Fairfield County area and personally introduced the author to senior leaders at the Connecticut Council of Philanthropy, Connecticut Health Foundation, and two community foundations to solicit funding for partial scholarships and to propose the SpringBoard to Board Service board match. All involved were very receptive to and supportive of nurse involvement in nonprofit board governance, and were especially interested in supporting specific diversity, equity, and inclusion efforts.

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Connections were forged with leaders of three community foundations across the state and Leadership Greater Hartford. To secure representation from across the state, specific organizations were targeted: FCCF in the southern western region; Leadership Greater Hartford in the northern and central region, and with limited statewide reach; the Connecticut Community Foundation in the northwestern region; and the Community Foundation of Eastern Connecticut in the eastern region.

Potential Obstacles to Project Implementation

The biggest potential obstacle to completing this project was the education and perception gap nurses experience when it came to their role on nonprofit boards. While many nurses engage in volunteer work in their community, they often do not consider board service. Nurses' perception of the financial responsibility and oversight necessary to meet fiduciary demands, including fundraising, is also a deterrent (Sundean, 2017). Apart from nurses in executive positions, many nurses lack financial acumen in their educational training, which is a hindrance to board service appointment. This gap may be a legitimate deterrent to nonprofits seeking board members who they can rely on not only for the community connections needed to advance their mission, but for financial support (Block & Rosenburg, 2002). In non-health sectors such as finance and legal, however, young professions frequently volunteer their expertise to nonprofit boards while building their professional capital, engaging in board service at a much early time in their career development. Replicating this kind of early service requires a culture shift within nursing to encourage volunteer service, especially on committees outside of nursing, as part of their professional development (Salmon, 2016; Sundean, 2017). This requires education on both sides and determining financial obligation up front in board interviews. Most nonprofit

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boards require participation but do not prescribe personal financial contributions. Established obligations can often be fulfilled indirectly by supporting fundraising activities or facilitating connections to potential donors.

It is also not clear how much nurses are willing to spend for this type of nursing education. Many programs that focus on placing women on boards are focused on for profit business and can be very costly, running anywhere from \$1,000 to \$5,000 depending on the offering institution. For example, Yale School of Management offers the prestigious Women on Board program which is targeted toward for-profit finance/business boards and not targeted to the nonprofit sector. Nurses, who are generally middle-income workers, are often deterred from these costly board programs. The nonprofit sector is a perfect arena in which to interact with a variety of professionals, to hone board competencies, and leverage connections with other influential community members and boards, at the local, regional, state, and national levels, and for-profit governance boards.

Nurses are often not considered potential board candidates and as a result are not invited to join boards. Many organizations may consider a physician, public health expert, or social worker as the preferred choice for a medical professional role on their board. This is largely a result of the public's recognition of nurses as caregivers rather than respected thought partners or co-leaders, which was the major impetus for this DNP project. Nonprofit organizations, which need strategic, mission-driven planning assistance, are a largely untapped arena where nurses can undoubtedly add considerable value. Nurse leaders are responsible for the delivery of safe and cost -efficient, patient centered care and are often experts in quality and safety improvement efforts. It is always possible that a nurse may not

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be a good fit for board, but successful board matching should be viewed as critical to effective governance rather than as a negative.

The COVID-19 pandemic that began in 2020 has put a spotlight on longstanding health inequities in the US. It has also provided an opportunity to leverage public attention on the nursing profession to highlight nurse leadership, and the need for nurse leaders to be part of key community and health care decision-making. The role for nurses in these venues is now being echoed and amplified at the federal level via initiatives of the Biden Presidential Administration, which has placed at least one nurse in a key role, including on the COVID-19 Task Force.

SARS-CoV-2 has also introduced a significant set of constraints on Americans in general, and this DNP project is in no way immune to those. Planning for the pilot had been underway for over a year when the coronavirus pandemic hit the US; while the group was able to complete their educational modules and meet in person several times, the final in-person sessions had to be shifted to remote meetings, as did mentorship and coaching.

Speaking more generally, there are many issues that will impact the field of nursing in the coming years and which have the potential to alter relationships among nursing and nonprofit partnerships. These issues include: the ongoing health care reform following the enactment of the ACA and the transition to a fee-for-value reimbursement model (VBP); the integration of new technologies; and the development of patient-centered care models.

Goals of the Project

The purpose of this quality improvement project was to prepare nurses for effective board service by:

1. Providing instruction and training on principles of effective board governance.
2. Helping nurses translate their skills into board competencies.

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3. Connecting nurses with nonprofit boards seeking nurse leader participation.

Aims of the Project

1. Collaborate in enhancing an educational program offered through the Connecticut Nurses Association to prepare nurses for board service.
2. Develop a board match process to help nurse participants in the educational program to make connections with nonprofits seeking board members in their communities.
3. Collaborate with CNA on a sustainability plan for the SpringBoard to Board Service educational and board match process.

Chapter 3: Methodology

Chapter three discusses in depth the program design, participants, and specific methods and tools used toward each of the three project aims. Participant selection, setting, timeline, and data collection, management, and analysis are also presented.

Program Design

The SpringBoard to Board Service program utilized a hybrid learning approach to prepare nurses for board service. While the original project design included the completion of eight self-paced, Best on Board (BoB) online learning modules and attendance at eight 3-hour monthly onsite sessions over an eight-month period, the coronavirus pandemic that emerged in the first quarter of 2020 necessitated a change in plans. The online learning proceeded unaffected but the final three of the eight monthly onsite sessions were held on the Zoom virtual meeting platform. A flipped classroom approach was used, and each nurse was expected to complete the assigned online BoB module and assigned readings prior to each onsite. The course was accessed through the BoB site with a special SpringBoard code and after completing the eight online modules, participants received a certificate of course completion from Best on Board. The CNA website hosted a dedicated SpringBoard webpage, via a secure portal, with all course information, and links to supplemental readings. All participants who were given temporary access into the system.

The monthly on-site sessions were held in Central Connecticut at Goodwin College, in East Hartford. During each of the onsite sessions, nurses had an opportunity to: network with each other and practice “elevator pitches” about their professional experience and interests; meet and learn from a content expert presentation; and participate in experiential learning vignettes that simulated board scenarios.

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Participant Selection

The goal was to recruit a cohort of 8 to 14 nurses to participate in the SpringBoard to Board Service program. The pilot was marketed online via intermittent blast outreach to all registered nurses in Connecticut by CNA through their database and the Board of Nursing registry with additional targeted marketing to members of Black and Hispanic nurse associations. To encourage participation, CNA priced the program reasonably at \$350, offered a discounted rate to CNA members, and offered partial scholarships to nurses of color. Nurses attending these sessions were also eligible to receive continuing education units (CEUs) for each session they attended and could earn up to 20 CEUs by attending the entire program. Recruitment ran over the summer of 2019 and the email blast outreach ended when the goal of 14 nurses was met.

Aims and Associated Methods

Aim 1: Collaborate with the Connecticut Nurses Association on their SpringBoard to Board Service initiative.

Methods of Achieving Aim One

- a. Develop learning vignettes to facilitate board service simulation in synchrony with monthly onsite CNA SpringBoard to Board Service sessions.

Learning board vignettes and learning activities were developed concurrently by the project team, with the aim of simulating board service scenarios. The vignettes addressed topics presented in the online learning modules to cover key aspects of effective board governance including fiduciary and stewardship responsibilities; supporting the organization's mission and stakeholders; strategic planning; finance; quality and safety; board-CEO relationship; and governance and leadership effectiveness.

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To develop learning vignettes, the author completed the Best on Board's *Essentials of Healthcare Board Governance* online course to become familiar with content covered in the modules. The eight online self-learning modules reviewed key aspects of effective board governance, including: fiduciary and stewardship responsibilities; supporting the organization's mission and stakeholders; strategic planning; finance; quality and safety; board-CEO relationship; and governance and leadership effectiveness. The learning vignettes developed focused on topics covered in each online learning module addressing core board competencies. Simulated nonprofit boards were created, and each participant was assigned a board member role to assume during the presented scenario. Participants role played and asked and answered questions as an imaginary board member during the simulation.

- b. Secure funding to offer partial scholarships and foster diversity, equity, and inclusion of cohort.

To foster diversity, equality, and inclusion, funding for partial scholarships for Black and Hispanic nurses were sought. Solicitation packets were made and distributed via email. The packet included a letter introducing the program, a sponsorship form, and the flyer created by Connecticut Nurses Association to market the SpringBoard program containing program details. This outreach was targeted to Funds for Women and Girls at the community foundations. Specific connections were also made to the president's discretionary fund at Connecticut Health Foundation, a nurse philanthropist and two community foundations introduced by FCCF.

Aim 2: Develop a board match process

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Methods of Achieving Aim Two

- a. Provide individualized coaching and mentoring for nurse participants throughout the board search and match process.

The board match service was introduced at the second onsite session as a voluntary add on to program. All 14 nurses in the SpringBoard to Board cohort were offered individualized board search coaching and mentoring to help nurse participants in the educational program to make connections with nonprofits seeking board members in their communities.

The author functioned as a personal board search coach and mentor for 10 nurses in the cohort who chose to engage in the board match process and facilitated connections for those interested in nonprofit board service. Participation in the board match process was voluntary and based on need. Some nurses came into the program with board service experience and were interested in learning about effective governance. Other nurses were able to establish their own relationships independently. A few came into the program with a particular nonprofit in mind, based on a preexisting relationship or with a goal to advance with an organization they were already working with. The board match service was an individualized 1:1 service independent of the SpringBoard coursework and tailored to meet the needs and readiness of each participant. The service was available for a period of 14 months which elapsed throughout and beyond the program duration, up until December 2020, depending on individual interest and opportunities. The board match process began with self-assessment to identify areas of expertise, passions and self-identified strengths. All Springboard participants received a CNA developed board search workbook as part of the curriculum. The workbook was used as a tool to help each candidate identify organizations and stakeholder groups that aligned with their interests and skill sets. Each

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participant had the option to network and explore ways of connecting with organizations to forge relationships on their own. During the second onsite, the Oregon Nurse on Board Initial Skills Assessment (Appendix A), an initiative of the Oregon Center for Nursing, was used to help identify their board competencies. At the third monthly onsite, all candidates were instructed on how to prepare board ready bio sketches. If a candidate wanted assistance, the author worked with them as requested. The cohort was encouraged to prepare and submit their board ready bio to CNA and be included in a book that would be disseminated at the networking event taking place in February 2020. The purpose of the networking event was to practice delivering elevator pitches, as well as to network with nurses serving on boards who could act as mentors and possibly facilitate connections to boards. The author worked with 10 nurses individually to prepare their board ready biographical sketches.

If candidates wished to pursue nonprofit board service, the nurses were then matched with relevant community foundations. Introductory emails were sent highlighting the candidate's passion areas and skill set to a prospective board along with their board ready bios. If the nurse was interested in a particular organization, the contact at the community foundation made an introduction. If the nurse needed help identifying an organization, the contact suggested potential nonprofits that aligned with nurses' passions and skill set. If the nonprofit identified was of interest, the contact then made email introductions for the candidate. The candidate was then responsible to follow through with interview process. Board appointment was not guaranteed, and candidates were not obliged to accept offers.

The goal was that by the end of the program or as interest and opportunity arose, candidates would:

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- Identify individual areas of expertise, passions, and goals for board service, and self-identified strengths
- Prepare a biographical sketch for board service
- Update professional resumes
- Identify potential nonprofits that align with participant’s passions, goals, and skill sets
- Connect to community foundation that would facilitate introductions to nonprofits identified.

b. Lead on CNA Board Search Workbook

Dr. Holle , VP CNA, developed a self-directed board search workbook to pilot as a tool to guide nurses through the board search process and on how to make themselves known to a potential board. The workbook was piloted as part of the nurse participants’ onsite curriculum, with a section assigned to be completed between each of the onsite sessions. The workbook was a self-paced activity and included: identifying personal strengths, identifying organizations aligned with passions, researching organizations, and identifying ways to connect and follow up with them. Each participant had the option to network and explore ways of connecting with organizations to forge relationships on their own. The author reviewed a section of the workbook at each onsite to help participants identify strengths, goals for board service and identify potential board opportunities that aligned with their passion and skill sets

c. Further develop relationships with nonprofits by piloting board match process

The SpringBoard to Board Service board match process was piloted with:

- The Connecticut Foundation of Eastern CT (CFEC)—Jennifer O’Brien, Program Director and Stephanye Clarke, Program Officer
- Leadership Greater Hartford (LGH)—Mae Maloney, Senior Director for Programs

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- Fairfield County Community Foundation (FCCF)—Karen Brown, VP and Tricia Hyacinth, Senior Director, The Fund for Women and Girls
- Connecticut Community Foundation (CCF)—Eileen Carter, VP of Programs and Strategies and Patrick McKenna, Program Officer

Aim 3: Create a sustainability plan for SpringBoard to Board Service educational and board match process, in collaboration with CNA.

Methods of Achieving Aim Three

- a. Evaluate SpringBoard pilot to determine further recommendations.

In collaboration with CNA, an evaluation plan for SpringBoard and future recommendations to the CNA board were developed. The Sudean Healthcare Index for Preparedness in Board Competency (SHIP-BC) was administered to assess level of confidence of each candidate at the beginning and at the end of the program

- b. Evaluate the CNA board's commitment to the SpringBoard program going forward.

A cost benefit analysis was performed to guide recommendations for CNA on future program cost effectiveness. In collaboration with Dr. Holle, a sustainability plan for who will lead any initiatives going forward was discussed.

- c. Determine CNA board's plan to maintain community connections.

With Dr. Holle, a sustainability plan was strategized to maintain connections to the community foundations and to be presented to the CNA Board of Directors. Further discussion included the possibility of CNA collaborating with Leadership Greater Hartford for a future partnership.

- d. Discuss with CCP the development of a more cohesive board matching program throughout the state.

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Results of pilot are planned to be shared with the community foundations and with the Connecticut Council of Philanthropy to explore possibilities for a more comprehensive and cohesive approach to board preparation and matching throughout the state, and to improving access to nonprofit board service.

Evaluation Tools

The Sundeane Healthcare Index for Preparedness in Board Competency (SHIP-BC) was used to assess level of confidence of each candidate at the beginning and at the end of the program (Appendix B). SHIP-BC is an evidence based, valid and reliable mechanism for self-assessing readiness for board service. SHIP-BC allows nurses to self-assess confidence and mastery over core board competencies in preparation for the board vetting process and board appointments.

SHIP-BC is an 18 item self-report instrument to assess nurses' self-efficacy with core board competencies. The 18 items were split into categories to match three *a priori* categories of board competencies referred to by Lee and Phan (2000) and the National Center for Healthcare Leadership (NCHL) Competency Model (Sundeane, 2017). The three categories include: personal/interpersonal skills (items 1-6), organizational/community awareness skills (items 7-12), and complexity/analytic skills (items 13-18). The survey is arranged as a 5-point Likert-type scale using end point anchors "not very confident" and "very confident." All items are positively stated, and reverse coding was not necessary for analysis.

Continuing Education Unit (CEU) process questions and post-session surveys were completed at the end of each onsite to confirm whether content covered learning activities,

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and guest speakers had enhanced the online learning modules. Direct observation and leader debrief were used as well.

Exit survey data was obtained via a 39-question Google survey (Appendix C) which participants were given time during the final Zoom session to complete. Qualitative data was also solicited through open ended discussion facilitated by open ended question prompts.

Data Collection, Management, and Analysis

Data collected included quantitative and qualitative elements to analyze the characteristics of the cohort, the utility of the board match process and the effectiveness of the program.

Quantitative data was collected on the cohort (N=14) to evaluate readiness, participation, and outcome. Readiness for board service was measured by the number of participants interested in finding a board position; number seeking board service; and the number of nurses who obtained a board seat. Participation was measured by attendance rates at monthly on-sites; BoB completion rate; number of nurses who used assistance to prepare board ready bios; number of bios submitted for networking book; and the number of nurses who utilized the board match mentorship and coaching. The Sundeane Healthcare Index for Preparedness in Board Competency (SHIP-BC) was administered before and after completion of the program to quantify pre- and post-training board competencies.

Qualitative data included demographic information, assessment of board competencies possessed, and confidence in board competencies. Demographic data elements included race; educational level; career experience; clinical expertise; and board/committee experience. Board competencies were identified by analysis of self-reported competencies in board bios, a qualitative approach to identifying confidence in competencies which was also

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quantitatively evaluated using the SHIP-BC scores mentioned above. The Oregon Nurse on Boards Initial Board Assessment tool was utilized to help nurses translate their skills into board competencies; however, this tool lacks content validity and reliability measures and is therefore an area for potential further instrumentation development.

All responses to surveys were anonymously given, collected, and further deidentified to conceal characteristics of the nurses in the program. The last session in June 2020 was used to collect program evaluation data. The exit survey data was collected and analyzed using Google Surveys. For the SHIP-BC pre- and post-test, a paired *t*-test was conducted using Excel, with *p*-values calculated to determine statistical significance.

Ethical Approval: Human Subjects

This quality improvement project was presented to Yale University's Human Research Protection Program on August 23, 2019. It was determined at that time that this project did not require Institutional Review Board (IRB) review for research of human subjects.

Project Team

- **Project Investigator and Doctor of Nursing Practice candidate:** Bernadette Park, MSN, RN, ANP
- **DNP advisor:** Carmen Portillo, PhD, RN, FAAN
- **DNP project team:** Jane Dixon, PhD, RN and Mary Ann Camilleri, JD, RN, FACHE
- **Project sponsors:** Connecticut Nurses Association
- **External DNP project mentors:** Cynthia Holle, DNP, MBA, RN, NHDP-BC and Lisa Sundean, PhD, MHA, RN

Chapter 4: Results and Discussion

Project Evaluation and Assessment

The Connecticut Nurses' Association SpringBoard to Board Service pilot program functioned from September 2019 through June 2020 with COVID-19 arriving in Connecticut on March 10, 2020. The cohort met in person a total of 5 times with 4 monthly on sites at Goodwin College (September, October, November 2019, and January 2020) and one networking luncheon event with nurses serving on boards in February 2020. The scheduled March onsite was cancelled and the last three sessions of the program were conducted virtually due to social distancing restrictions during the height of the first phase of the COVID-19 pandemic of 2020. Based on cohort surveys, the onsite activities reinforced the essentials of all board governance for effective leadership, including knowledge about the board's fiduciary and quality and safety roles, its stakeholders, and its mission driven strategic planning.

Participation:

Thirteen of the 14 participants (93%) were actively engaged in the program, attending over 70% of the program either in-person, virtually, or both. Eleven of those 13 participants (85%) remained committed until the program's conclusion and completed exit surveys despite the interruption of COVID-19 and change in program delivery.

Description of Cohort

Fourteen female nurses self-selected to enroll in the pilot. Six (43%) were nurses of color who received partial scholarships; eight were white.

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Education: All participants held or were working toward higher degrees in nursing. Seven (50%) had doctoral degrees, two (14%) were in the final semester of a doctoral program, and five (36%) held a Master of Nursing degree.

Expertise: The cohort's nursing practical experience included a diverse range of settings representing a range of 10- 40 years of experience. Nine participants (64%) were full- or part-time nurse educators; two (14%) were hospital administrators. A Nurse Practitioner, a certified registered nurse anesthetist (CRNA), and a public health [nurse/professional] were also in the group. Nursing specialty areas represented included pediatrics, women's health, school health, higher education, gerontology, veterans' health, public health, behavioral mental health, and pain palliative care.

Board Governance experience: Ten nurses (71%) had board governance experience coming into the program. Four nurses (29%) were currently serving on a board, including one serving as Board President. Three nurses (21%) were serving on their professional nursing board and one nurse was serving on the Department of Health committee in her town. Additionally, six nurses (43%) had professional organization and healthcare committee experience.

Board Competencies

The cohort possessed the following board competencies based on skills identified in the 12 board ready bios completed: twelve (100%) communication and content expertise; nine (75%) quality improvement/safety; Six (50%) strategic planning; Three (25%) fundraising; and Three (25%) finance. One participant (10%) had legal/health policy consultancy competencies.

Readiness for Board Service: Based on the 11 exit survey, six participants (55%) came into the program interested in learning more about board service and four (36%) wanted to join a board. One said they were currently serving on a board and wanted to improve or further develop

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her board competencies. One nurse serving on a town committee attended 50% of the program to develop board governance understanding and attended the networking event. One nurse moved out of state and was able to rejoin when virtual sessions began; she came into the program knowing organizations she wanted to contact and successfully joined committees.

Results of Aim 1: Recruit and prepare nurses for board service

Aim 1a: Develop learning vignettes

Three board simulations were developed and facilitated: Introduction of fiduciary responsibilities; Mission driven strategic planning; and board role in Quality and Safety. Dr. Holle is an MBA with content expertise and led the financial role learning activity. Dr. Sundean created an asynchronous session to enhance the CEO and board relations learning module.

Results of surveys: Based on post-session surveys/CEU responses, author observations and leader debrief, the cohort enjoyed role playing activities and actively participated. And based on exit survey, nearly all (91%) respondents felt the in-person sessions extended learning and that the board simulations and learning activities enhanced the online learning.

Aim 1b. Secured funding for partial scholarships

Fairfield County Community Foundation (FCCF) and Connecticut Health Foundation each offered \$800 grants to fund partial scholarships for nurses of color. The CNA opted not to follow through with grant request applications but did offer partial scholarships to nurses of color which ensured a diverse cohort.

Results for Aim 2: Developed a Board Match Process

Aim 2a: Provided individualized coaching and mentoring

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Despite the disruption of COVID-19, the board match process continued between March and December 2020. Ten nurses (71%) participated in the board match process. Relationships had been forged with candidates during monthly on-sites while working with them on board simulation activities and the board search workbook assignments. One-to-one assistance for writing board ready bios was provided while participants also began to prepare for the February networking luncheon. Assembling a Board Bio book to be presented at the networking event incentivized the cohort to submit their board ready bios. Ongoing communication with the cohort was maintained via email and utilizing Google Docs and Microsoft Word files to edit board bios. Email communication effectively connected nurses with potential boards. Nurses interviewed virtually.

Both the philanthropies and nonprofits the nurses connected with had not previously realized that nurses are underrepresented on boards and were enthusiastic supporters of nurse board service. Offers of board appointment were not guaranteed, and candidates were not obliged to accept offers when they were made.

Seven of the eight (88%) board match participants matched with a board by July 2020. Ultimately, 50% of the nurses interested in pursuing nonprofit board service in their community chose to serve on professional organization boards both at the state and national levels as their preferred entry into board service. While the match process aims to make meaningful connections nurses and nonprofit boards based on interest, mission, and competencies, securing the board seat is a distinct next step requiring an offer (from the organization) and an acceptance (by the nurse leader), neither of which is guaranteed. As of December 2020, only one interested nurse had not secured a board seat, though she had matched successfully with four nonprofits in her community. Two board CEOs were in the process of presenting the candidate to their board

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of directors for consideration when pressing community needs resulting from the pandemic arose, and succession planning was temporarily sidelined. One organization, a Federally Qualified Health Center (FQHC), did not offer an appointment, stating they wanted a representative from the community they served. One did not respond to introduction. Nurses who secured a board seat began attending board meetings virtually.

Aim 2b: Piloting the Board Search Workbook

Of the 11 participants who returned the exit survey, six (55%) participants completed the entire board search workbook, and four (36%) completed portions of it. The section of the workbook that provided examples of how to make themselves known to a board was said to be the most helpful.

Aim 2C: Further develop relationships with nonprofits

The connections formed with the community foundations and Leadership Greater Hartford over the summer and fall of 2019 proved to be extremely beneficial. Relationships were deepened with Fairfield County Community Foundation (FCCF), Leadership Greater Hartford and Eastern CT Community Foundation. These organizations facilitated initial introductions to nonprofit boards for four nurses. Two nurses from Northwest Connecticut did not pursue nonprofit board service in their community so the board match process with the Connecticut Community Foundation was not able to be tested.

What did nurses find to be most helpful?

Preparing Board ready bios and facilitating community connections was found to be the most helpful aspect of the board match process. Preparation for board interviews was found to be moderately helpful, along with guidance translation of skills into board competencies. Below are the mean results of the exit survey:

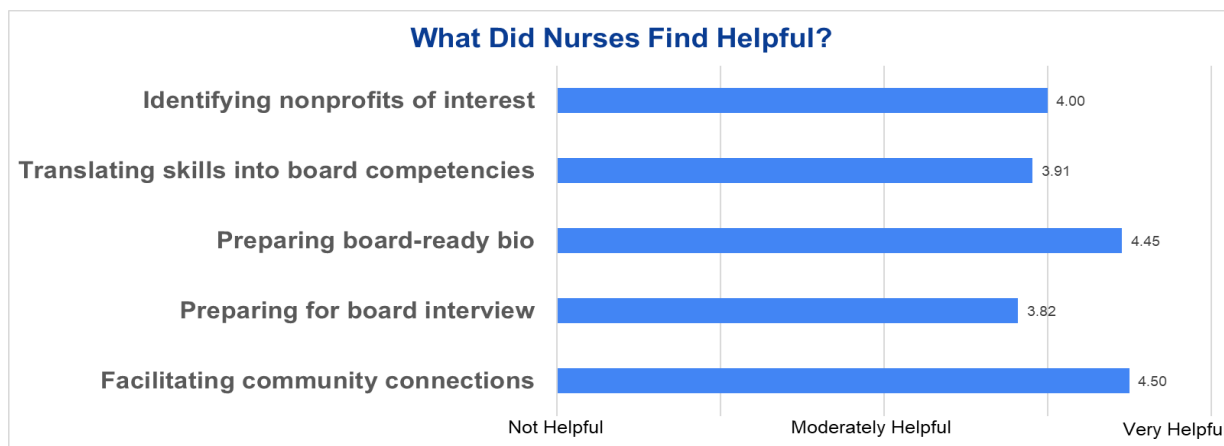


Figure 2: SpringBoard to Board Service Exit Survey results.

How the Board Match was used:

Who used the board match process?

Ten nurses (71%) requested individualized assistance with their board search. Eight (57%) of fourteen nurses engaged in the full board match process and sought board service. Ten (71%) participants received assistance preparing board ready bios for the networking board book. None of the participants utilized help to prepare for interviews.

Where did the nurses match?

Half of the nurse participants seeking a board position knew of an organization that they wanted to serve or found an organization through the board search process. The other fifty percent were newly introduced to an organization they were interested in matching with. Five nurses (36%) matched with nonprofits in their communities. Three nurses (21%) accepted a board position with a nonprofit in their community that aligned with their passions and skill sets: home care hospice/palliative care, child protection, and domestic violence services, respectively. One nurse matched with two community health organizations but chose a national organization serving veterans that she found on her own. One nurse had a possible pending match with two

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organizations- a college or career mentoring program and a health and human services agency. One nurse had a goal of creating a women's health nonprofit and was referred to Leadership Greater Hartford for when they are ready to select board members. One nurse serving on the Connecticut League of Nursing board utilized the board match service. She added national board service and nominated herself for a new role as treasurer. Yet another nurse joined the CNA board as treasurer.

Two (25%) nurses used the board match service but were not ready to seek a board position at this time. One was struggling with family responsibilities and unable to fully attend to time required for search. She moved to her vacation home with limited internet service during pandemic and ongoing communication was impaired. The other nurse was not ready to seek board service.

Nurses who did not use board match:

Four nurses (29%) opted not to use the board match service offered. One nurse who was serving in her town DOH did not fully engage in the program and attended only half the sessions. One nurse moved out of state during the program but continued to participate via Zoom when sessions were virtualized. She joined the Outreach Committee for the Certification Board for Diabetes Care and Education and the Education Committee for the National Association of Hispanic Nurses. Two nurses currently serving on professional nursing boards, reported improved understanding of the importance of diversity for effective governance because of the SpringBoard program. As a result, they were developing criteria for board recruitment and succession planning and adopting a diversity lens to find candidates that filled gaps in expertise lacking on their board

Six-month follow up:

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In December 2020, board match participants were contacted via email to do a six month follow up. Seven of the board-matched participants (88%) are attending board meetings virtually; and all are satisfied with their board service.

Results of Aim 3: Created a sustainability plan

The monthly CEU process questions/post-session surveys completed at the end of each onsite supported the hypothesis that content covered, learning activities and guest speakers had enhanced the online learning module.

The following findings are based on responses of 11 of the 13 (85%) nurses who completed the exit survey. The results of exit surveys were overwhelmingly positive.

Program delivery

Participants reported having a good understanding of the responsibilities inherent in effective board membership. Ten (91%) felt that course content adequately covered the board competencies; that 9 months was the right amount of time required to engage in the board search and match process; and that the cohort size of 14 was optimal. All respondents (100%) felt the program should include in-person sessions; Ten (91%) felt the program should include virtual prep work.

Ten (91%) of the cohort valued the peer-to-peer networking that the program provided and felt that the simulated board vignettes, learning activities and guest speakers reinforced online learning modules. The same number (91%) also found the network luncheon where they heard the experiences of other nurses who had secured board positions and could network directly with nurses on boards, to be very helpful. None suggested any changes to program

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delivery outside of increasing onsite time to allow for more unstructured time to network with each other.

Sudean Healthcare Index for Preparedness in Board Competency			
<i>Scale from 1-5 where 1 is Not Confident and 5 is Very Confident</i>			
<i>P-Value test results below means that improvement in skill category is:</i>			
<i>Significant: <=.05</i>			
<i>Marginally significant: <=.10</i>			
<i>Insignificant: >.10</i>			
	Average	Average	
	Pre	Post	P-Value
Complexity/Analytic Skills			
I ask probing questions to gather information	4.0	4.2	0.08
I manage competing interests in complex situations	3.8	4.2	0.08
I think broadly to expand my knowledge of situations	4.2	4.3	0.34
I seek expert perspectives to solve problems	4.3	4.9	0.03
I am focused and confident during change	3.7	4.1	0.02
I create innovative approaches for solving problems	4.0	4.7	0.01
I am willing to take risks for calculated benefits	3.9	4.7	0.00
	4.0	4.4	0.08
Personal/Interpersonal Skills			
I promote team leadership behaviors throughout the organization	4.3	4.6	0.22
I promote strong working relationships throughout the organization	4.3	4.6	0.17
I hold others accountable for their performance in the organization	4.0	3.9	0.36
I take responsibility for my actions and decisions in the organization	4.8	4.8	0.50
I serve as coach and mentor to others to develop healthcare talent	4.4	4.7	0.17
I set organizational priorities based on evidence	4.1	4.2	0.34
	4.3	4.4	0.30
Community/Organizational Skills			
I advocate for necessary community health needs at the local, state, and federal levels	3.2	3.8	0.05
I contribute to the identification of the organization's strategic mission and vision	4.2	4.2	0.50
I build relationships with influential people who share common health interests and needs	3.4	4.1	0.04
I am aware of internal and external influences on the organization	3.8	4.2	0.05
I address health needs in a culturally sensitive, patient- and community-centered manner	3.8	4.4	0.07
	3.7	4.2	0.14

Table 1: SHIP-BC Pre- and Post-Test Results Using Paired t-tests.

The SHIP-BC was administered on the first day of the program and electronically during the last session. Thirteen (93%) nurses completed the pre-test; nine nurses (65%) completed the pre- and post-test. One post-test was discarded because the nurse had not completed the pre-test. Results are based on the 9 out of 14 (65%) respondents who completed the pre- and post-test.

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On a Likert scale (0-5), all reported confidence of > 3 coming into program in all domains. The lowest scores were in Community/Organizational skills. The average (mean) score was 3.2 for advocating for necessary community health needs at the local, state, and federal levels and 3.4 for building relationships with influential people who share common interest and needs. A *p*-value was calculated for the SHIP-BC pre- and post-test (paired *t*-test) with significant improvement ($p < .05$) noted in Complex/Analytic Skills and Community/Organizational Skills.

Despite coming into the training with some confidence (4.0 out of 5), the average participant had an increase in confidence in preparedness for board competencies after the training (4.5 of 5). The ratings for all items assessed in the questionnaires show improvement post-training, with an average increase of 0.5 points on the Likert scale.

Nurses reported that facilitating community connections and learning how to make themselves known to boards as beneficial aspects of this program. However, nurses can and were able find their own board positions. Half of the nurse participants knew or identified a board they wanted to serve on. The 50% of the nurses who did utilize the board match process chose nonprofit board service in their communities. Those who chose professional or national board service are considering adding nonprofit board service but were advised to wait a year so that multiple board commitments would not impact their ability to be an effective fiduciary for organizations. Follow-up of these nurses to see if they forge these relationships and serve in this capacity is recommended.

The piloted Board Search Workbook developed by Dr. Holle was confirmed as a valuable tool. Coupling the workbook with mentorship throughout the program to help nurses identify potential board service that aligns with their passions and skill sets was very effective.

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Cost Benefit Analysis

The pilot was offered to cohort at \$350 per person. The price was intentionally low to encourage pilot participation. Partial scholarships were offered to nurses of color to ensure cohort diversity. The nursing workforce's diversity and their ability to be educated healthcare provider and community voices was a major incentive for community foundation and nonprofits supporting this initiative. The undiscounted rate is estimated to be \$550. (See Appendix D for details of Cost Benefit Analysis.)

To offset costs and offer pilot at a reduced rate, Dr. Holle, VP CNA volunteered her time to lead this effort. Onsite space was donated by Goodwin College. CNA used residual funds from the Connecticut Nursing Collaborative-Action Coalition supporting the Culture of Health Initiative. Additional funding for partial scholarships for four nurses of color was solicited from the Connecticut Health Foundation and Fairfield County Community Foundation but ultimately CNA opted not to submit grant applications.

The estimated cost of pilot is \$16,860 (\$1204.00 per participant). Soft cost (two instructors and space) is estimated to be \$12,200 (\$871 per participant) and is currently donated. Hard costs including online license, administrative assistance, books, refreshments, and supplies are estimated to be \$4,660 (\$330 per participant). Without funding, the pilot would be operating at loss (\$540). If the SpringBoard program continues and is offered at \$550, it would only be profitable +2200 if the soft costs (instructor time and space) continue to be donated.

The price nurses are willing to pay for this type of professional/leadership development still needs to be determined. While eight of the eleven participants (73%) reported in the exit

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survey that they would invest \$300 to \$599 for a complete program, eight of the fourteen nurses enrolled in the program (57%) received scholarship funds and paid \$220 for the pilot.

Discussion and Recommendations

This was a cohort of motivated nurse leaders drawn from a diverse range of backgrounds, training, and experience. Based on cohort surveys the onsite activities reinforced the essentials of all board governance for effective leadership, including knowledge about the board's fiduciary and quality and safety roles, its stakeholders, and its mission driven strategic planning. The importance of the funding from Fairfield County Community Foundation (FCCF) and Connecticut Health Foundation (CHF) notwithstanding, the community foundations' ability and willingness to connect nurses with nonprofits was an invaluable contribution to the success of this program. This speaks to the value of connections and content expertise as equal in importance to financial contributions.

The most consequential update to the program future since the pilot was conducted is that Leaders on Board has been converted to a fully virtual curriculum. This was an important development that has the potential to radically alter the opportunity to board match for nurse leaders. Throughout the region there are hundreds of nonprofits seeking to enhance the quality of life in their communities and improve the lives of their neighbors and constituents. Leaders on Board helps nonprofits find new members who bring their diverse perspectives, skills, and experiences to the important work of their organizations.

Specific author recommendations for future program implementation and enhancement are as follows:

Board Governance Vignettes: Multiple vignettes were developed and customized which centered on various aspects of board governance as part of the SpringBoard to Board Service in-

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person sessions. Going forward, it is suggested that developing a simulated organizational board and building vignettes around a single issue the board is confronting would allow for a more realistic experience. It is recommended to continue to assign each participant different roles on the board to demonstrate need for DEI in board composition.

Emotional Intelligence Assessment:

During board simulation activity sessions, participants varied in their ability to “lean in” appropriately. Some leaned in too much, others too little. This may be attributed to confidence; this was a cohort with board experience and not afraid to share their opinions or ask questions. In fact, a few sometimes monopolized discussions, especially when interacting with guest speakers and during board simulations. This was intimidating for a few nurses who were less verbal and ultimately were not ready to seek out board service. Once identified, a guest speaker with content expertise was scheduled to attend the fourth onsite but onsite coincided with COVID-19 and unable to reschedule. The asynchronous session recorded by Dr Sundean addressed the need for respectful discourse during board discussions. In hindsight, it was concluded, with Dr. Holle, that the group would have benefited from tools to increase self-awareness. In the future, the first onsite session would be best used for self-assessment and include an Emotional Intelligence Assessment as well as the Oregon Nurse on Board Initial Skill Assessment. Overall, the cohort enjoyed learning from and supporting one another.

Mentorship and Coaching: One-to-one assistance to nurses in translating their skills into board competencies and help preparing board ready bio sketches may be the way to move going forward, as it is easily incorporated into most programs by virtue of being assigned as work to be done between sessions.

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Formalize Partnership with Leadership Greater Hartford: It is recommended that the SpringBoard to Board Service program, in conjunction with the board match process, be run in partnership with Leadership Greater Hartford. To that effect, Leadership Greater Hartford has offered to help place nurses on boards and is willing to collaborate with CNA to offer board match events as needed.

Board Match Workbook: There is a comprehensive board workbook under development at the Nurse on Board Coalition (NOBC) which is, in the author's opinion, a somewhat more suitable tool than the Holle Board Match Workbook for these purposes. The use of this workbook for future cohorts is recommended if permissions are secured. Dr. Holle will revise the Holle Board Match Workbook if needed.

Connecticut Nurses Association Continuity: The project team is recommending that the CNA continue to offer the SpringBoard to Board Service program in the piloted hybrid format. However, because all participants felt strongly that the program should include in-person sessions, the program will not be offered again until COVID-19 social distancing restrictions are lifted and safe to gather.

Dr. Holle, VP CNA, is committed to nurse leadership and to continuing the SpringBoard program. She will be presenting pilot findings to the CNA Board of Directors. Since leadership at nonprofit organizations is not static, CNA will need to continue to cultivate and maintain the relationships forged with community foundations, CT Health Foundation, and Leadership Greater Hartford. These connections are best overseen by CNA's leadership subcommittee. CNA is considering an annual information session/luncheon event to invite philanthropy to attend and educate them on the work CNA is doing, the importance of nurse leadership and their board service as it relates to promoting a culture of health and health equity.

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The benefits of the SpringBoard to Board Service program cannot be quantified in dollars. The program encourages nurses to lend their voice to boardrooms and impact board governance. Connecticut nurses will develop board leadership skills and become visible as leaders in their communities.

The CNA plans to increase the cost of the program to \$550 when offering it again. This will still require supplementing with grants and the instructor(s) and educational space to be donated.

Conclusion

Overall, this pilot was successful in teaching effective governance principles and the cohort found the content and experience beneficial. Nurses reported that facilitating community connections and learning how to make themselves known to a board were the most beneficial aspects of the program. When combined with the board match process, the preparation resulted in seven of the ten nurses (70%) acquiring a board seat.

Nurses are confident and have board competencies but do not often consider nonprofit board service. Five of the eight (63%) who utilized the board match service and interested in nonprofit board service, chose a nonprofit focused on health equity for their first board service experience. Three of eight (37%) chose a professional organization as their first board service experience. The COVID-19 crisis shone a bright light on health disparities and elevated the need for nursing leadership. This crisis presented an opportunity to leverage community connections and build upon them to raise awareness for the need to have nurses at key decision-making tables.

Nurses value and benefit from having a venue to gather for peer-to-peer mentoring, networking and to support and learn from each other. However, care must be taken not to

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perpetuate the cycle of nursing in silos. This cohort benefited and forged connections outside of the profession, but much work needs to be done by nursing to forge connections outside of the profession and to be effective change agents and work collaboratively as thought partners in multidisciplinary teams to achieve health inequity and address the root causes of SDOH in their communities to foster a community of health. To that end, it may be beneficial to offer the board match service targeting nurses currently serving on professional boards to consider adding nonprofit board service.

There is a need to replicate these findings with other populations especially with baccalaureate (BSN) level nurses. Introducing volunteering on nonprofit board service as a form of nurse leadership earlier in nursing education would be beneficial. The nonprofit sector is an excellent arena to hone board governance skills. The concept of board service as a form of nurse leadership also needs to be incorporated earlier into nursing education with volunteering for community service and committee work as a critical first steps to being recognized as leaders in their communities and to be considered for board governance opportunities.

The nonprofit sector, including philanthropies, community foundations, and community-based organizations addressing SDOH and working with marginalized populations, were overwhelmingly receptive to supporting the SpringBoard to Board Service cohort and their subsequent board match efforts because these partnerships align well with existing diversity, equity, and inclusion efforts. Having community voices at decision-making tables is a goal for many organizations, and it is commonly agreed that nurses can and should be that voice. The diversity of the nursing workforce and their ability to be an educated healthcare provider and community voice was a major incentive for community

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foundation and nonprofits supporting this initiative. The nonprofit sector needs a more democratic process if improvements in access to board service are to be effective and if community voices are to be included at the table.

Appendix A

Oregon Nurses on Boards Initial Skills Assessment



Oregon Nurses on Boards Initiative
 Presented by Oregon Center for Nursing
 Adapted by Ericka Waidley, MSN, MA from BoardSource
www.oregonnursesonboards.org

Initial Skills Assessment - *FOR NURSES CONSIDERING SERVING ON BOARDS*

An organization that's recruiting a new board member will – depending on the organization's stage of development, current board members, and other factors – seek out candidates with particular strengths and qualities. Here's a self-assessment form to help you gauge your specific assets across a range of metrics.

On the form, rate yourself from 1 - 5, where 1 = you do not have that skill or characteristic, and 5 = one of your strongest skills or characteristics.

Availability for Active Participation						
	1	2	3	4	5	N/A
Committee work						
Marketing						
Program support						
Lobbying						
Fundraising						
Volunteering						
Speakers Bureau						

Areas of Expertise						
	1	2	3	4	5	N/A
Administration/Management						
Entrepreneurship						
Fundraising						
Government						

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Community Connections						
	1	2	3	4	5	N/A
Religious organizations						
Corporate						
Education						
Media						
Political						
Philanthropy						
Small business						
Social services						
Other						

Personal Style						
	1	2	3	4	5	N/A
Consensus builder						
Good communicator						
Strategist						
Visionary						
Bridge builder						

Qualities						
	1	2	3	4	5	N/A
Leadership skills/Motivator						
Willingness to work/Availability						
Personal connection with the mission						

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Qualities (continued)	1	2	3	4	5	N/A
Financial Management						
Accounting						
Investments						
Law						
Marketing, Public relations						
Human resources						
Strategic planning						
Physical plant (architect, engineer)						
Real Estate						
Representative of clients						
Special program focus (e.g., education, health, public policy, social services)						
Technology						
Other						

Other skills and expertise you have to offer:

Appendix B

version 8.10.17

1

**SUNDEAN HEALTHCARE INDEX FOR
PREPAREDNESS IN BOARD COMPETENCY
SHIP-BC**

Thinking about your leadership skills, rate your level of confidence about the following behaviors:

	Not Very Confident	-	-	-	Very Confident
Complexity/Analytic Skills					
1. I ask probing questions to gather information.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I manage competing interests in complex situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I think broadly to expand my knowledge of situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I seek expert perspectives to solve problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I am focused and confident during change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I create innovative approaches for solving problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I am willing to take risks for calculated benefits.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal/Interpersonal Skills					
8. I promote team leadership behaviors throughout the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I promote strong working relationships throughout the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I hold others accountable for their performance in the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I take responsibility for my actions and decisions in the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I serve as a coach and mentor to others to develop healthcare talent.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I set organizational priorities based on evidence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community/Organizational Skills					
14. I advocate for necessary community health needs at the local, state, and federal levels.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I contribute to the identification of the organization's strategic mission and vision.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I build relationships with influential people who share common health interests and needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am aware of internal and external influences on the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I address health needs in a culturally sensitive, patient- and community-centered manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Interpretation:

- It is recommended that nurses demonstrate confidence with all items in the SHIP-BC when preparing for board service.
- For items or general categories **with ratings below** Confident or Very Confident, consider seeking professional experiences and educational opportunities to strengthen mastery of these competencies.
- For items or general categories **with ratings of** Confident or Very Confident, consider specific examples that demonstrate mastery of these competencies. Specific examples to demonstrate competence will strengthen candidacy for a board appointment.
- The SHIP-BC is a survey of personal competencies for healthcare board service. It is also in the best interest of nurses preparing for boards to have **functional knowledge of healthcare delivery systems, performance requirements, business, finance and human resources**. Not every board member needs to demonstrate competence in each of these areas, but a full board of directors should comprise strong competence in these domains. Competence in these domains will strengthen candidacy for a board appointment.

* The SHIP-BC should be used in combination with other experiences, resources, and programs to ensure board readiness.

**The SHIP-BC is based on the core competencies from the Center for Healthcare Governance (2009) and the categories described by Lee and Phan (2000) and the National Center for Healthcare Leadership (2006).

***Psychometric evaluation of the SHIP-BC (formerly known as the Healthcare Board Competency Survey for Nurses – HBCSN) is available: Sundean, L.J. (2017). Healthcare board competency survey for nurses: Assessing board readiness. *Nursing Economic\$,* 35(6), 295-303.

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Appendix C

SpringBoard to Board Service Exit Survey

1. I enrolled in the SpringBoard program because:
 - a. I wanted continuing education
 - b. I was interested in learning more about board service
 - c. I wanted to join a board
 - d. I serve on a board and want to improve/develop my board competencies
2. Did you complete the assigned pre-work?
3. If you encountered barriers to completing the pre-session work, please give a short description.
4. Did you find the hybrid format helpful?
5. Did the in-person sessions allow you to extend the pre-session learning?
6. If you answered no in #5, why not?
7. Should future SpringBoard programs contain (check all that apply):
 - a. In-person gatherings
 - b. Virtual pre-work
 - c. Live online sessions (Zoom, Teams, etc.)
8. Thinking about the length of the Saturday sessions, 9-12, do you feel the length of the session was too short, just right or too long?
9. What do you feel is the optimal number of participants in a SpringBoard cohort with an in-person component?
10. Weighing the value of time to engage in the board search process against the challenge of committing to nine sessions over 8 months, do you feel the length of the program as designed (before the COVID interruption) was too short, just right or too long?
11. What do you feel is the optimal span of the program for both delivering the competency content AND accomplishing the board search tasks?
12. If SpringBoard were shorter than its current 9 months, with the same content, would you support two in-person gatherings a month; one full-day in-person gathering a month; or keep one in-person gathering a month but reduce the number of months?
13. How valuable did you find having guest speakers/content experts?
14. Do you feel you had the opportunity to engage with the speakers/content experts?
15. Do you feel the guest speakers, on average, represented subject matter expertise in the topic of the module/competency of the month?
16. Given the description of cost, and in comparison, with other courses you have engaged in, what do you feel is the appropriate participant investment for this complete program?
17. SpringBoard content was centered on board competencies as found in both the Curran book, Nurse on Board, and the Best on Board online program. Thinking about these

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competencies, did you find the course content covered too little, was just right or covered too much?

18. After completion, how well do you understand the responsibilities of an effective board member?

- a. fiduciary duties: care, loyalty, obedience
- b. mission-driven strategic planning
- c. financial role
- d. role in quality and safety
- e. CEO-board relationships

19. How would you describe your BOB completion?

20. Did you find the BOB content difficult to master or unclear?

21. If you completed BOB, will you note that completion on your CV, resume, LinkedIn profile, or similar?

22. How important is completion of the BOB certificate to you?

23. For the modules you completed, did you feel BOB helped prepare you for the in-person session?

24. Please rate the course materials on their helpfulness in gaining understanding of board competencies.

25. Did the board learning activity/ simulation reinforce content covered?

26. Please rate the networking luncheon in these areas:

- a. opportunity to network with nurses on boards
- b. opportunity to hear how other nurses got on boards
- c. opportunity to display my interests and skills
- d. impetus for completing my board bios
- e. opportunity to gain a mentor
- f. opportunity to practice my elevator speech

27. Did you complete the Board Search Workbook?

28. If you did NOT complete the Board Search Workbook assignments, why?

29. Please rate the aspects of the Board Search Workbook.

30. Did you participate in the board match program?

31. Answer these questions about how and when you gained awareness of nonprofits in your community that aligned with your passions and skills:

- a. I already knew of an organization I wanted to serve
- b. I identified organizations during board search process
- c. I was introduced to an organization that was new to me

32. Were you matched with a board?

33. Are you serving on the board you matched with?

34. If you gained a board seat, does the board placement align with your passions?

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35. If you gained a board seat, does the board placement align with your skillset?
36. How helpful was assistance with the following?
 - a. Identifying nonprofits of interest
 - b. Translating skills into board competencies
 - c. Preparing a board-ready bio
 - d. Preparing for a board interview
 - e. Facilitating community connections
37. How could we improve the board match process?
38. Would you recommend SpringBoard to Board Service to a colleague?
39. Is there any other feedback you would like to share with us?

Appendix D

SpringBoard Program - Cost-Benefit Analysis

Program Description: SpringBoard is a not-for-profit education program which prepares CT nurses for service on boards of HC orgs, charities, community groups and municipal government.

Program Benefits: The benefits of this program simply cannot be quantified in \$. Instead, the program encourages nurses to lend their voice to the boardroom and helps CT nurses develop their leadership skills more broadly.

Assumptions:

Program Size	14 persons
Software Licensing Cost	\$ 150 per person
Books	\$ 20 per person
Refreshments & Supplies	\$ 5 per person
Networking Event	\$ 1,250
Administrative Assistant	\$ 960 (\$30 per hr * 4 hr sessions * 8 sessions)
Instructor Time (hrs)	
Onsite	64 (2 instructors * 4 hr sessions * 8 sessions)
Lesson Planning	32 (2 instructors * 2 hr per session * 8 sessions)
Networking	24 (2 hrs * 12 organizations)
Matching	56 (4 hrs * persons)
Mentoring	52 (1 hr per week * 52 weeks)
Total Instructor Time	228 hours a year
Instructor	\$ 50 per hour
Classroom	\$ 800 (\$100 per room session * 8 sessions)

Hard Costs:

Software Licensing Cost	\$ 2,100
Books	\$ 280
Refreshments & Supplies	\$ 70
Networking Event	\$ 1,250
<u>Administrative Assistant</u>	<u>\$ 960</u>
Total Hard Costs	\$ 4,660
Total Hard Costs per person	\$ 333

Soft Costs:

Instructors	\$ 11,400
<u>Classroom</u>	<u>\$ 800</u>
Total Soft Costs	\$ 12,200
Total Soft Costs per person	\$ 871

Total Implied Costs per person **\$ 1,204**

Program Sustainability:

Goal: SpringBoard is a not-for-profit organization

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providing financial aid for those who require assistance.
To sustain itself, the program requires donations.

Program Fees	\$ 350	per person
Financial Grants:		
Grantees	4	persons
<u>Financial Grants per person</u>	\$ 200	
Total Financial Grants	\$ 800	
Financial Projections:		
Program Fee Revenue (Gross)	\$ 4,900	
<u>Financial Aid</u>	\$ (800)	
Net Program Fee Revenue	\$ 4,100	
<u>Hard Costs</u>	\$ (4,660)	
Program Income/(Loss)	\$ (560)	
Minimum Grants to cover Hard Costs	\$ 560	excludes donation of instructor time & classroom from Goodwin College

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