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Enabling nurses to lead change: The orientation experiences of nurses to boards

AnnMarie Walton, MPH, RN, OCN, CHES,[a,*] Donna Lake, PhD, RN, NEA-BC,[b] Connie Mullinix, PhD, RN,[b] Deborah Allen, PhD, RN, CNS, FNP-BC, AOCNP,[c] and Kathi Mooney, PhD, RN, FAAN[a,d]

[a] The University of Utah College of Nursing, Salt Lake City, UT
[b] College of Nursing, East Carolina University, Greenville, NC
[c] *Duke Cancer Institute, Duke University, Durham, NC*
[d] Huntsman Cancer Institute, University of Utah, Salt Lake City, UT
[*] Corresponding author: AnnMarie Walton, Pittsboro, NC 27312. Email: Annmarie.walton@utah.edu (AnnMarie Walton).

Abstract

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Objectives

Nurses need to be full partners in shaping health care and health care policy. One way to do this is to be present and active on boards at all levels. The purpose of this study is to examine the orientation experiences of nurses to boards and their preparation to influence health care and health care policy.

Methods

A Web-based survey about the efficacy of board orientation was sent to members of three local boards made up exclusively of nurses.

Results

Liabilities and fiduciary duties were least likely to be addressed in board orientation for nurses. Board members requested more training in finance and a more formal/structured orientation process.

Conclusions

Standardizing orientation elements for nurses serving on boards would best prepare them to serve on interprofessional hospital boards and work in the health policy arena. The orientation experience on local- and state-level nursing boards is fundamental to nurses beginning board service.

Keywords: Nurses on boards, Board orientation

Background

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Nurses need to be full partners, influencers, and advocates in shaping health care and health care policy. Boards of directors make strategic decisions about the directions organizations will go, so having nurses on boards that are health care related, especially hospital boards, is crucial. Nurses are underrepresented on boards (Hassmiller, 2013). In 2005, a study of 14 U.S. nonprofit general hospitals found that 52 (26%) of 203 board positions were

held by physicians, whereas only four (2%) of 203 board positions were held by nurses (Prybil, 2007; Prybil et al., 2005). Among nonprofit community health systems, approximately 2.5% of voting board members were nurses, whereas physicians held 22% of voting board positions (Prybil, 2007; Prybil et al., 2005). A more recent survey by the American Hospital Association (AHA) of over 1,000 hospitals in 2010 found that nurses made up only 6% of board members, whereas physicians held more than 20% of board seats (AHA, 2011). News articles in trade publications are also asking why there are no nurses on hospital boards (McCurdy, 2013).

Nurses, although trusted health care professionals, are not regarded as influencers. A 2010 Gallup poll funded by the Robert Wood Johnson Foundation asked 1,500 thought leaders which health professions would have the greatest influence in health care reform in the next 5 to 10 years and nurses ranked the lowest (Gallup, Inc, 2010). Some say the stereotype of nurses is to see them as implementers of care rather than decision makers of care. Yet, many nurses are highly educated, hold several degrees, and have held leadership positions in the hospital setting and community (Meyers, 2008). Qualified nurses are urged to offer their services as opportunities arise and not wait to be asked to serve on boards (Hassmiller, 2008).

Little attention had been placed on nurses' involvement on boards until the Institute of Medicine (IOM) published its recommendations for the future of nursing (Institute of Medicine, 2011), which call for nurses to be on boards. Recommendation 7 states, "Prepare and enable nurses to lead change to advance health" (IOM, 2011, p. 14). In fact, as recently as November 2014, the Nurses on Board Coalition announced their launch of an effort to place 10,000 nurses on governing boards by 2020 (American Association of Colleges of Nursing, 2014).

Nurses have the unique responsibility of bringing the business of caring to board agendas and bringing "the bedside to the boardroom" (Spinks, 2006). Nurse executives are charged with the induction of non-members to the health care industry by giving them opportunities to regularly interact with patients and the professionals who serve them. Nurses and nurse executives also have expert knowledge of how to best achieve high-quality, safe care (Hassmiller, 2013). They are uniquely positioned to make sense of the data sets, tie in the patient experience, and generate solutions for their board colleagues to consider (Holt, 2010). In fact, chief nursing officers have much greater familiarity with IOM reports on patient safety and quality of care than chief executive officers (Meyers, 2008). Nurses can offer new solutions and understand the collaboration that will be needed between health care professionals and health care settings. Because nurses are known for good listening skills and asking the right questions to solve problems and highly functional team members, they are also seen as good board members. They are excellent patient advocates (Hassmiller, 2013). Doctorally prepared nurses in particular are able and qualified to converse easily about data collection and analysis, outcome management, and financial management (Thorman, 2004). Articles cite the need for the nurses' knowledge on quality, safety, and patient care at the board level of health care organizations (Hassmiller, 2012a, 2012b; Hassmiller & Combes, 2012; Mullinix, 2011; Prybil, 2009).

Boards are held accountable for functioning at a high level. Governance reform activities are also demanding increased performance and accountability for governing boards. The AHA's blue ribbon panels on health care governance and development of trustee core competencies are examples of the response to these demands (Cornwall & Totten, 2011). At least 12 states offer board education and performance criteria for hospitals and health care systems. Massachusetts and South Carolina offer some insurance benefits to hospitals if their boards complete specific training, and New Jersey mandates 7 hours of education for every health care organization trustee. "Best on Board" (www.bestonboard.org) is one example of an education, testing, and certification program for board members and can be completed online or on-site. The certification is valid for 3 years, and then board members can recertify (Curran & Totten, 2010). Another example of standardized training for nurses is Sigma Theta Tau's Non-Profit Board Governance for Health Care Leaders Online Education Program (www.nursingknowledge.org). This program is a 2-year training that includes a 3-day continuing education

course, a personal action plan, online readings and discussions, a mentorship/ shadowing opportunity, and a familiarity with resources for continued lifelong learning related to board leadership development. A novel course regarding nurses and board leadership has been created at the East Carolina University School of Nursing and is open to master's and doctoral students in nursing. It is currently “live” for its first semester in an asynchronous online format. Immersion in board activities is a key part of board orientation (Carlson et al., 2011), but there is little in the literature about how that occurs outside of these training programs.

Nurses use the literature from nonprofit organizations (Biggs, 2011) and materials developed by the AHA such as their publication, Trustee, the journal for members of hospital boards of directors. An emerging source of information for nurses on boards is the evolving research on the increased effectiveness of boards with women members (Zaichkowsky, 2014). An effort to define competencies for board service, although not research based, is found in the work by Westphal and McNiel (2014). There is no nursing literature on orienting nurses for board service or functioning as a member of a board. Writings merely call for nurses to be a part of health care organization's boards.

Nurses are often encouraged to begin their relationship with board service by volunteering and serving their professional nursing organizations where they can gain leadership and skill development (Hill, 2008). Experienced board members who are nurses report that they began their service on boards as members of local and state nursing association boards and learned much from that experience (North Carolina Nurses Association, 2012). How, then, are nurses oriented to board positions on boards that are made up purely of nurses? If service to and growth within these organizations and on these boards is to be a stepping stone to broader board service, attention to orientation on our own boards demands attention. Thus, the purpose of this research was to explore the processes and topics used by boards of North–Carolinaebased nursing organizations to orient new board members. We undertook a survey of nurses serving on the boards of local nursing organizations and examined their orientation experiences. In both written and verbal communications with these boards, strategies were recommended for orienting nurses to boards.

Sample

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A convenience sample of 46 board members was eligible and invited to participate in a survey about their board orientation experience. Three nursing organizations were invited to participate in this research about their board orientation experience for a total of 46 eligible members: the NCNA (n = 11), the North Carolina Organization of Nurse Leaders (n = 23), and the Triangle Chapter of the Oncology Nursing Society (n = 12). Although the first two organizations are state-level organizations, the third organization does not have a state-level membership but is broken into chapters. The Triangle Chapter is considered a “mega-chapter” serving over 600 members, making it larger than the North Carolina Organization of Nurse Leaders, which has over 250 members. The NCNA serves the largest membership with over 4,500 members. The NCNA is not a specialty nursing organization.

Methods

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The study was reviewed and approved by an institutional review board before commencement. Board members of the three organizations received an explanation e-mail with a survey link. The e-mail explained that entering the survey site would serve as consent to participate in the study. A statement was also made that participants could choose not to finish the questionnaire or omit any question they preferred not to answer. All responses were anonymous, and only aggregate data were shared.

An interview guide was created by the principal investigator (PI) and a coinvestigator after a review of the literature focused on best practices in board orientation. The work of Shultz (2001), “The Board Leadership Development Program” from Sigma Theta Tau International (2014), and the “Best on Board” training (Nursing

Knowledge International, 2013) program were used to determine key components of the board orientation process. These components were used as the survey questions that were reviewed and revised by the investigators in this study. This final interview guide (Table 1) called the Efficacy of Board Orientation for Nurses survey was created in SurveyMonkey (Palo Alto, CA) and piloted with five senior nurse executives who were not on any of these three boards but were or had been on other boards. Three of the five senior nurse executives responded and provided survey data and construct suggestions that assisted in revising the survey. The nurse executive pilot test participants reported the survey was completed within 5 minutes and easy to comprehend. Minor changes were made by the authors after the pilot test.

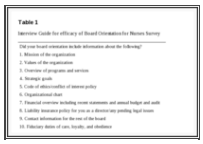

Table 1

Interview Guide for efficacy of Board Orientation for Nurses Survey

The final survey included 14 dichotomous questions about whether or not the board member participated in aspects of board orientation that are considered to be best practices. Also, one additional dichotomous question was added about whether or not the board member felt continuously trained. In addition, there were three open-ended questions to allow board members to comment on the most valuable parts of orientation, what was missing from their orientation experience, and what training they thought they needed to be successful in their board role. Finally, demographic questions were asked including age, gender, ethnicity, job title, whether or not it was the members first time on a board, and how many years served on the board.

To initiate the study, the PI invested in relationship building among the various professional organizational board presidents. For example, the PI corresponded in person and electronically with the board presidents of each of the organizations about the study, the literature, and survey goals, which resulted in their participation in the study. Key to the initial communication was the agreement that the PI could observe and/or review their board and orientation processes. The PI attended board meetings for each of the organizations, and some were considered ongoing orientation sessions for new and current board members or included the welcome of new members to the board. Each of the presidents agreed to e-mail the survey to their board members. In continued correspondence with each president and administrative staff, the PI ensured there was a total of three electronic mailings of the Efficacy of Board Orientation for Nurses survey 1 week apart from each other. These electronic mailings were sent to the board on a weekly basis for 3 weeks.

Results

Go to:

The response rate at the end of the three e-mailings to each of the three groups was 69%. The 32 respondents were predominantly female (97%, n 29, two missing) and ranged in age from 25 to 74 years with 51% over the age of 55 (n = 16, one missing). The majority of respondents (65%) had not served on a board before (n = 21), and the years of service among respondents ranged from less than 1 to over 10, with 30% serving less than 2 years (n = 10), 27% serving between 2 and 3 years (n = 7), and 43% serving more than 4 years (n = 13, two missing; Table 2).

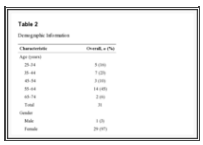

Table 2

Demographic Information

Liability insurance and fiduciary duties were the two areas respondents were least likely to be informed about; across all organizations, only two people reported being informed about liability insurance policies, and only 13

respondents reported receiving information on the fiduciary duties of care, loyalty, and obedience, which are foundations of board service (Association of Governing Boards of Universities and Colleges, 2014).

Personal introductions and contact information for the board were most likely to be included in the orientation. Across all organizations, the vast majority (80%, $n = 26$) of respondents said that they had an opportunity for personal introductions and that they got contact information for the rest of the board (75%, $n = 24$). Table 3 shows the combined results of all three organizations with regard to topics covered and not covered.

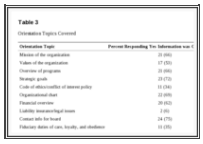

Table 3

Orientation Topics Covered

There were areas for immediate improvement for all organizations. Sharing information on the code of ethics policy for the organization, having a handbook or thumb drive for members to refer back to, and a call or meeting 3 months into board service made by the board president are relatively easy to do.

The three open-ended questions were content analyzed with a focus on counting recurring themes. Board members across all organizations valued the personal introductions, especially when they had contact with outgoing board members who may have filled their specific role. The value of information about the organization and its strategic goals and a handbook or thumb drive to reference also emerged across respondents from all organizations.

Among what was missing from the board orientation experience, respondents across the organizations wanted more of a financial overview, and several asked for a more structured/formal orientation process. Desired training that was mentioned across all organizations included mentorship/experience from those who had their role previously and/or those who had the same role in another chapter/state. Only one organization had 100% of respondents report that they felt continuously trained.

Limitations

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Some of the limitations of this study are that it had a small sample size, was performed all in one state, and included only boards comprised of all nurses. In order to have more generalizable results about the orientation experiences of nurses, a larger national sample of nurses serving on boards (including those who are serving on boards where they might be the only nurse) should be conducted. A replication with the parent organizations at the national level might also be useful.

Strengths

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This was the first study of its kind to specifically ask nurses serving on boards about their orientation experiences. The response rate was high, and the board presidents were open to receiving the study findings and using them to improve their board orientation experiences. The impact of the research findings will be used immediately and will have an impact on the preparation of nurses on these boards who will likely serve on additional boards during their careers. In fact, two of the organizations surveyed have proposed a revision of their orientation process to their current board members.

Discussion

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Nurses are valuable members on boards and are encouraged to get their start on the boards of local- and state-level nursing organizations of which they are members (Hill, 2008). A paucity of literature exists on the

orientation experience of nurses to boards. Three local- and state-level nursing organization boards were surveyed to get a better understanding of how nurses were oriented into those positions. Although there were some significant differences within organizations, overarching results showed that nurses received and valued personal introductions and contact information/networking with other board members. They did not receive information about their liability insurance as a director nor the fiduciary duties of care, loyalty, and obedience, which are central to board service. Improvements to the orientation experiences of two of these groups of nurses would have included a handbook/thumb drive to reference and a check-in at 3 months into their service. Additional training recommendations across organizations included mentorship from previous board members/those holding the same position elsewhere and more financial review. Only one organization achieved success at the continuous training of their board members. It is noteworthy that two boards specifically asked for a more structured and formalized orientation. Because all of these organizations are state/chapter subsidiaries of larger organizations, the parent organizations could be examined for their structure orientation program to see if it could be modeled.

Furthermore, because nurses serve on various types of boards, the board orientation experiences and recommendations of other industries are worth consulting. For industry and nonprofit boards, orientation serves to prepare all board members of the organizational mission, vision, goals, and accomplishments (Berit, 2007). Although the chief executive officers of industry boards tend to lead the orientation process, it is up to the outgoing and incoming presidents to organize and lead the voluntary nursing board orientation event. Some nonprofit organizations bring in facilitators for the structured orientation event so the incoming president can participate in the process with the full board (Ford, Gresock, & Peeper, 2011). The desire for a structured orientation was heard throughout our survey responses.

It is suggested that boards incorporate the use of mentoring, or pairing an experienced board member with the new member, to ease assimilation to the board (Finkelstein & Mooney, 2003). Additionally, most industries provide manuals before the structured event for review of the organizational mission, history, bylaws, and budget including currently funded projects. Membership feedback, organizational strengths, needs, characteristics, prior priorities, and achievements may also be included in the manual or within the structured event (Finkelstein & Mooney, 2003). Likewise, our respondents spoke to the desire for a manual or resource to consult after the formal training. Furthermore, the desire for mentoring was mentioned in the open-ended responses and in personal interactions with members of each of these three boards.

Several nonprofit organizations use board member agreements to match organization bylaws with organization expectations of board member performance. These agreements may serve as metrics for meeting attendance, role, communications, conduct, and level of engagement between the organization and the board members (Taylor, Marino, Rasor-Greehalgh, & Hudak, 2010). Using some of the industry standards in board orientations will only serve to improve our nursing board experiences and build on known qualities that could assist nurses on boards. Looking more broadly, local- or state-level nursing organization board orientation has the power to train nurses in concepts that are crucial and transferrable at the executive-level skill. For example, one respondent in the narrative comments mentioned wanting more information about “teamwork and group process.” Two respondents said they wanted more information about “strategic planning.” Getting these skills from serving on a local or state nursing board would contribute to leadership skills development and position nurses for interprofessional boards at the hospital, community, and national levels. Filling these roles confidently contributes to nurses being full partners in health care collaboratives and as advocates for health care policy and transformational change.

At the end of their term, nurses on boards comprised solely of nurses should be encouraged toward broader positions in the health care arena. Encouraging nurses who are part of nursing organization boards to broader

service makes lighter work of the goal to get 10,000 nurses on governing boards by 2020, a direct response to the IOM report, The Future of Nursing: Leading Change, Advancing Health (2011), which recommended nurses play more pivotal roles on boards and commissions in improving the health of all Americans.

Conclusion

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This survey offered an opportunity to explore the orientation experience of members of local- and state-level nursing boards compared with orientation elements recommended by industry and nursing leadership organizations. From the literature on the orientation of board members (not orientation for members of nursing boards), content and processes for onboarding new board members was identified. The boards surveyed used few of the options for educating board members about their liabilities and responsibilities. In both written and verbal communications with these boards, strategies were recommended for orienting nurses to boards. Several components of a thorough orientation experience were missing from the experiences of these members. The survey results in combination with the literature reviewed are helping to strengthen the orientation programs of each of the organizations that participated. They can also be used to standardize orientation elements for nurses serving on boards to best prepare them for service on interprofessional hospital boards and beyond as well as preparation for work in the health policy arena, which are the foci of the coalition. Therefore, the orientation experience on local- and state-level nursing boards may be the most critical and fundamental to nurses beginning board service within these contexts. As nursing embraces the importance of board service, especially on inter-professional hospital boards and beyond, the literature including research on board competencies and effectiveness will develop.

Acknowledgments

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Footnotes

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