VOICE of nursing leadership

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MARCH 2021 DIVERSITY AND INCLUSION

Voice of the President

Mary Ann Fuchs, 2021 president, AONL Board of Directors

In 2011, the Institute of Medicine, now National Academies of Sciences, Engineering and Medicine, published the landmark *Future of Nursing: Leading Change, Advancing Health* report, which contained a recommendation to increase the diversity of the nursing workforce at every level of the health care system. The report was updated in 2016 and prioritized the lack of diversity in the profession as a persistent challenge, as evidenced later by a 2017 survey conducted by the National Council of State Boards of Nursing (NCSBN) and the National Forum of State Nursing Workforce Centers. The survey reported the demographics of the profession as: 80.8% White/Caucasian; 6.2% African American; 7.5% Asian; 0.4% American Indian/Alaskan Native; 0.5% Native Hawaiian/Pacific Islander; 1.7% two or more races and 2.9% other. We can and must do better.

One of the areas of focus of the current Future of Nursing 2020–2030 committee is to identify the systemic facilitators and barriers to achieving a workforce that is diverse including gender, race, and ethnicity, across all levels of nursing education. The timing could not be better.

The AONL board has focused on the area by reviewing our bylaws, developing educational content and appointing board members to increase the diversity necessary for our organization. This past fall the AONL Diversity and Belonging Committee began its work. The committee's leaders, President-elect Erik Martin and appointed board member Joy Parchment, have convened members several times to draft a mission, vision and conceptual framework. With the vision "to unleash the potential of a diverse and collective nursing community," this committee's work will drive the future direction of AONL.

> We are confronting racism head-on because we recognize it as a public health crisis and a roadblock on our path to zero harm.

As your AONL president, I am participating in the newly convened National Commission to Address Racism in Nursing. The co-leads

Continued on page 26

AONL American Organization for Nursing Leadership™

AHA News

U CAN

BE THE CHANGE YOU WANT TO SEE IN THE WORLD

As California's #1 hospital (#4 in the nation), we're proud to serve an incredibly diverse population. We're deeply passionate about being active advocates for healthcare equity as well as committed champions for social justice in every area of our lives.

Recent events clearly demonstrate the need to continually challenge the status quo and seek new solutions to lift up and empower the marginalized among us. At UCLA Health, we'll be on the front lines in the fight for positive change.

As a nurse leader, you can help us continue to advance our culture of equality and inclusion.

Search openings and apply today at **UCLAHealthCareers.org** or connect with us at one of our upcoming virtual events at **UCLAHealthCareers.org/events**

UCLA Health | VALUING THE DIVERSITY THAT'S U

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AONL education calendar

March 2021		
Finance and Business Skills for Nurse Managers	March 5, 12, 19	Virtual
April 2021		
Developing the Leader Within	April 22–23	Virtual
June 2021		
Leadership Lab: Leadership Development for Nurse Managers	June–December	Virtual
July 2021		
AONL 2021	July 11–14	Washington, D.C.
August 2021		
AONL 2021 Virtual Experience	Aug. 4	Virtual
Nurse Manager Institute	Aug. 18–20	Virtual
October 2021		
Certified Nurse Manager and Leader (CNML) Essentials Review Course	Oct. 5, 12, 19, 26	Virtual

Visit **aonl.org** for the latest information on AONL virtual, on-demand and in-person programs. Locations and dates are subject to change.

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Have you moved, changed jobs or switched addresses? Go to **aonl.org/myaccount** to update your information and explore your profile.

Creating More Diverse C-Suites: From Intention to Outcomes

M. Jane Fitzsimmons, MSN, RN
Angelleen Peters-Lewis, PhD, RN, FAAN

Over the past year, nurse executives have been called upon to respond to dramatic clinical, economic and professional disruption, including resource and workforce shortages because of the COVID-19 pandemic. The greater incidence and less favorable clinical outcomes of the pandemic on minority populations, coupled with concurrent racial unrest, have coalesced to underscore major fault lines within our health care system. These recent events have highlighted the disparities in clinical outcomes for diverse populations as well as the value of diverse executive leaders in health care.

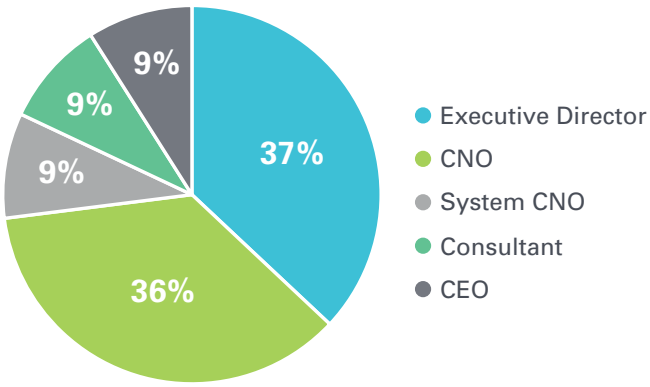
Diverse leaders bring a unique understanding of cultural differences that impact health, values and beliefs in addition to the experience of race in America. The addition of a diverse perspective to leadership teams can help organizations improve racial health disparities and employee and patient experience. In order to create organizations that effectively address the first issue—disparity of clinical outcomes—successful organizations must create diverse executive and senior leadership teams reflecting the populations served and the cultural dynamics of the current and emerging workforce.

Despite a quarter century-plus of monitoring leadership diversity in health care by national professional organizations, little progress has occurred. While women represent 66% of the health care entry-level workers, they hold only 30% of the C-suite positions, while minority women hold only 5% of C-suite positions in health care (Berlin et al., 2020). Are these statistics evidence of discrimination and racism within our health care system? Further, what barriers do diverse leaders face in obtaining, maintaining and advancing their leadership careers and what can be done to eliminate or overcome inequalities that do exist?

To answer these questions, the authors of this article designed and conducted a survey, fielded in 2018 and 2019, to gain a better understanding about barriers to career advancement and recommendations for future leaders by sampling successful diverse nursing executives and senior leaders. The respondents (N=50) represented diverse leaders holding prominent positions in health systems, academic medical centers, hospitals and educational institutions (Figure 1).

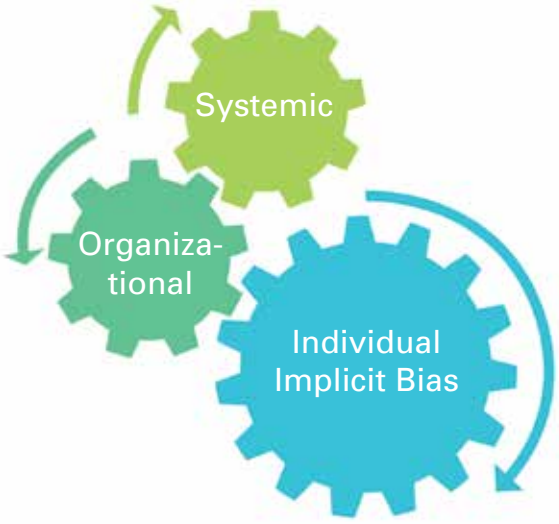
Ninety percent of the respondents stated that they had "experienced barriers to career advancement due to their race." One of these highly successful nursing leaders described her experience of others assuming she was a "patient transporter because of (her) race", while another described being told by members of the board, "you will not last in your role because they don't like Black people here;" yet another diversity candidate was told that while she had interviewed well, "maybe it's just your face, but the CEO doesn't think you would fit in here."

FIGURE 1: Respondents' Current Role in Leadership



Of those who experienced racism, 100% believed the barriers become increasingly prevalent when advancing to the executive level. One respondent noted, "with the sought-after jobs" the experience can be "tortuous." While diverse leaders report that the proper education and credentials are essential, more than a few stated that minorities must far exceed the required standards for education, credentials and experience than their majority race counterparts. One respondent explained, "Meeting the standard is not good enough, you must exceed the standard to be accepted." In

FIGURE 2: Systemic Racism



fact, many others mirrored this sentiment. For example, respondents recounted instances where white candidates with less experience were selected over a more qualified diverse candidate. As one recalled, "I have applied for positions for which I was qualified and had the necessary experience and the job was given to someone with less preparation, skill, and experience." Another shared, "I have been singled out for doing extraordinary work but overlooked for advancement. It is almost like I am invisible."

These results were similar to a qualitative study (Paraway, 2017), that found "African American and Black nurses" were perceived to "lack credibility, competence and respect" providing further evidence that "organizational racism exists."

Different types of racism

The experiences cited by survey respondents clearly identified barriers to their career advancement. This begs the question of whether this is due to racism within our health care organizations. It is important to understand that racism takes on different forms and is expressed in a range of severity, from unintended discrimination to antagonistic racial or ethnic aggression. It is important to note, however, that both individual and organizational racism may be unintentional.

On a personal level, everyone has implicit bias which develops as a normal part of our neurological anatomy and life experiences. It influences our world view and decision-making often, at an unconscious level. We are hard-wired to favor what is familiar and to feel less safe with the unfamiliar. We tend to like people who look, think and act like us, which can result in unintentional discrimination and prejudice. In fact, the barriers faced by minority sub-groups and the effects of organizational racism are often invisible to the majority white culture.

At the organizational level, structured racism can occur when policies, practices and traditions are designed to work better for the majority culture than for people of color. If the leadership team of an organization is all from the majority culture, it is only natural that the systems created will favor the majority values and perspectives. Given that health care leadership, as mentioned, has been dominantly comprised of individuals from the white majority culture, the executive perspective is representative of that same majority culture. This allows little space for the values and perspectives of those outside the majority culture, namely people of color, to be expressed, heard and honored, not only in our health care leadership, but in the populations we serve. Even as an organization tries to become more inclusive, the barriers and obstacles that need to be changed are frequently not obvious to the majority leaders.

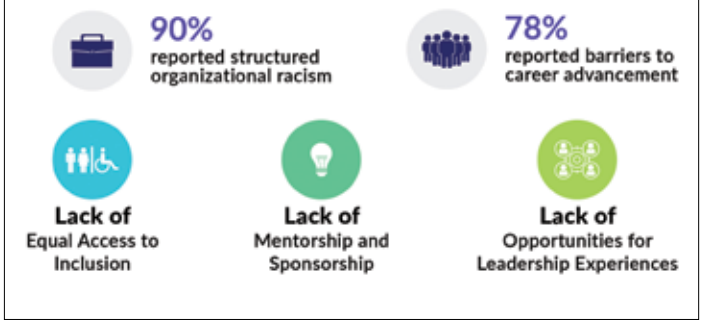
Systemic racism occurs when there is a long history and current reality of organizational racism across all institutions combining to create a system that negatively impacts communities of color. Given our lack of success in increasing the diversity among health care executive teams, we can safely say that, despite good intentions, health care suffers from systematic racism (Figure 2).

Barriers to career advancement

In an effort to understand the obstacles to advancement experienced by diverse nurse leaders, the survey asked respondents to identify what they perceived to be the top three barriers to career advancement (Figure 3). The responses highlighted three major areas:

- Unequal access to opportunities
- Absence of mentorship and sponsorship
- Lack of opportunities for leadership experiences

FIGURE 3: Survey Results



Numerous examples of unequal access to opportunities were described. Many respondents referred to a lack of inclusion in the inner circle. One respondent observed, "Executive-level positions depend on who you know and often we are not included in the inner circle and may not even be unaware that an opportunity is available." Another remarked, "Individuals that move to the executive level

position typically have [professional] connections that help propel their career. Minorities for the most part do not have these connections."

In addition to exclusion from inner circle knowledge, respondents believed there was frequently an absence of a fair and equitable selection process. One respondent described the situation from the viewpoint of being a member of the selection committee. "I have participated in many search committees. Even if there is conversation about keeping an open mind to a diverse pool of candidates, the results seldom occur." The selection team "has to make a commitment to hire someone that doesn't look like them, think like them and has had different experiences."

The second most often identified barrier to advancement was a lack of mentorship. "You have the right qualifications, but you do not have leaders from your race to facilitate your advancement because they are not in positions of power." Given the scarcity of minorities in executive leadership roles, respondents indicated that it is important to have majority race leaders who were willing to act as mentors to emerging diverse leaders. While many respondents credited mentors as important to their career success, others found it challenging to build those relationships. "It is difficult to build relationships with people who will mentor you," said one respondent, while another noted, "Minorities are under a microscope and organizations will not take chances on you." Having a mentor from the majority culture was perceived as especially beneficial because white leaders can assist a minority professional to "learn the rules of engagement and navigate the nuances of the cultural and political systems."

The third area that respondents selected as a barrier to advancement was access to leadership experiences and the chance "to be visible and showcase your talents." Many identified this as a deficit that occurs during early to mid-career. "I felt that the organization could not see me as a viable candidate for executive roles." Diverse professionals are often not given the opportunity to work beyond their position in a way that promotes visibility and builds confidence and experience. "Many [diverse] nurses have limited networks, few mentors and no meaningful avenues of mutual support" (Wesley & Dobal, 2009). Diverse nurses fail to advance beyond clinical and middle management positions, looking in anticipation through a glass ceiling to an unattainable goal (Qaabidh et al., 2011).

Organization leaders must examine who is recommended or selected to make presentations, serve as chair councils, attend conferences or serve in interprofessional roles. These mid-career experiences are fundamental to moving beyond the scope of an existing role by interacting with others across disciplines and across the organization. They also offer the opportunity to be recognized and to showcase skills to new stakeholders. According to one respondent, the lack of these mid-career opportunities often results in a diverse candidate's having a "slimmer resume" than his or her counterparts.

Moving beyond racism

Survey respondents shared numerous recommendations to promote equity and inclusion in health care organizations and to develop more diverse leadership teams.

1. **Create safe spaces for self, organization and systems**
   - Establish safe spaces for team members to learn more about themselves and one another as a way to activate a culture of belonging and subsequent safety among employees.
   - Convene forums for authentic dialogues on race, racism and injustice.
   - Understand terminology, concepts and practices related to diversity, equity and inclusion (DEI) standards and expectations within the institution.
   - Speak candidly and learn about the challenges of achieving diversity, equity, inclusion and belonging in both the workplace and our communities at large.
2. **Promote equity**
   - Provide the same things to all people to achieve equity and provide what each person needs.
   - Teach colleagues about implicit bias.
   - Engage in respectful dialogue and build trust to understand needs. Devise new approaches and tools that allow everyone to contribute to their fullest.
   - Examine and redesign policies, procedures and practices.
   - Take bold steps to eliminate favoritism, structure, policies and practices that perpetuate organizational racism.
3. **Reassess your recruitment and advancement processes**
   - Prepare your organizational culture to embrace diversity and inclusion, creating an environment that will welcome diverse leaders.
   - Open your mind to many possibilities and people; do not appoint "someone you know."
   - Develop measurable criteria to drive the selection process. Do not base such important decisions on likability.
   - Think more broadly about leadership; consider potential and ability vs. pigeonholing people based on their current roles.
4. **Require a diverse pool of candidates from your search firm**
   - Consider a blind review of resumes in initial screening.
   - Insist on candidates that bring quality, competency and diversity.
   - Develop measurable, objective criteria for success in the role.

- Use candidate interview questions specific to the criteria for success.
- Create an evaluation tool based on objective, measurable factors.
- Provide consultation to prepare the search committee and guide the internal process.
- Make decisions based on evaluation data and objective interviewer feedback.

5. **Progress from mentorship to sponsorship**
   Mentors are invaluable in proving career guidance. Sponsorship, also called intentional inclusion, describes a more formalized relationship that is focused on the advancement of the protégé. Sponsors open doors and provide access to relationships and opportunities. Three ways to promote sponsorship:
   - Create guidelines around sponsorship to ensure that cross-demographic sponsorships are common.
   - Develop a strategy to encourage a culture of sponsorship.
   - Ensure that employees from underrepresented backgrounds and their achievements are visible and celebrated at rates at least as high as those from well-represented backgrounds.
6. **Create infrastructure to monitor and track progress**
   Expand, diversify and track the effectiveness of mid-level professional development programs. Assess the results of these outreach programs to determine what is working and what is not effective.
7. **Dismantle racism – become anti-racist**
   Don't get stuck in the fear zone; move to the learning and growth zone (Kendi, 2019). Apply a racial equity lens everywhere, including:
   - Patient satisfaction
   - Employee engagement
   - Access and wait times
   - Quality outcomes
   - Attendance policy
   - Succession planning/promotions

Next steps

As an informed executive, you must assess the environment within your current organization. Does it promote fair and equitable processes? Do you engage one on one with diverse nursing leaders? Promoting growth, advancement and inclusion are the first steps towards achieving increased diversity in health care leadership. Given the challenges of implicit bias, be intentional in creating inclusive environments and be extra vigilant when developing recruitment, leadership development and career advancement processes.

When you feel like you don't have the energy to commit, to partner, to lead from the bedside or when you grow weary, remember the words of Martin Luther King, Jr.: "All labor that uplifts humanity has dignity and importance and should be undertaken with painstaking excellence." ◆

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AONL Advocacy Day 2021

Raise the voice of nursing leadership on Thursday, May 27, AONL's Advocacy Day. AONL members will meet with legislators to offer nursing expertise on the issues critical to the field. Check **aonl.org/advocacy** for the latest information on this event.

Addressing Inequities Through Nursing Education and Practice: Rush Nurses Support the Mission

Laurie Ouding, RN, LNC
Denise Sanchez, MSN, RN, CCRN
Monique Reed, PhD, RN
Angela Moss, PhD, APRN
Janice Phillips, PhD, RN, CENP, FAAN

Nurses across the Rush University System for Health are leaders in supporting the organization's commitment to achieving health equity, eliminating health disparities and supporting diversity. The health system includes its flagship hospital, nationally ranked Rush University Medical Center, Chicago, Rush Oak Park (Ill.) Hospital and Rush-Copley Medical Center, Aurora, Ill. Rush University offers a wide variety of educational opportunities, including a college of nursing, known for preparing the next generation of nurse leaders. On any given day—at the bedside, in the classroom or the community—Rush nurses are leading efforts to improve the health and well-being of patients and communities. This article details a few examples of the many ways in which nurses are leading efforts to address inequities.

Food security at the bedside

Food security is one of the most significant determinants of health influencing the well-being of individuals, families and communities. The U.S Department of Agriculture defines food insecurity as a household-level income economic and social condition of limited or uncertain access to adequate food. According to Feeding America (2020), food insecurity has intensified during the pandemic. Experts project as many as 54 million people who will experience food insecurity, including 18 million children.

As a pediatric nurse for 35 years, I have seen first hand the results of food insecurity in my patients and noticed an alarming increase in obesity rates and diabetes among children aged 2 to 18, as well as children suffering from nutrition-related illnesses. Within the city of Chicago, rates of obesity are elevated in socioeconomically disadvantaged areas such as North Lawndale (23.4%), a predominantly African American neighborhood, compared to Norwood Park (14.4%), a more affluent and mostly white neighborhood. There is likely a correlation between food insecurity and obesity, given the high rates of food insecurity in North Lawndale compared to Norwood Park, 37.4% and 7.1% respectively. This is one example of how living in one ZIP code with minimal resources, such as adequate food, can have a direct impact on health outcomes.

Nurses at Rush University Medical Center address food insecurity through the Food is Medicine Program. Nurses begin by screening patients for any unmet social needs such as access to stable housing, ability to pay utilities, food security, having a primary care provider and insurance, and access to transportation. Specific to food security, we ask, "Are you worried about food running out before you have money to buy more?" and "In the last 12 months have you run out of food that you bought before you have money to buy more?" Patients who answer positively are then connected with resources within Rush and within their own communities, as well as receiving a box of healthy foods delivered to their homes after discharge from the hospital. I lead efforts to engage other members of the health care team in addressing this issue. In 2020, Rush delivered 37,500 pounds of food and screened a total of 18,887 people across the Rush Health system. ***– Laurie Outing, RN, LNC***

Improving health literacy

I was called to action as a young nurse in the cardiac ICU, combating an old stereotype. Here, the term *frequent flyer* brought up images of inpatients with acute decompensated heart failure admitted three or four times a year. The negative connotation was often accompanied by eye rolls from staff nurses and laments from cardiologists, *"How can they be hospitalized again?"*

One 30-year-old patient had a left ventricular ejection fraction of 10% and uncontrolled hypertension. He sat on his bed with his back to the door with an Against Medical Advice form in his fist, ready to leave preemptively as he had

so many times before. It occurred to me I could let him leave the hospital or I could attempt to understand the pattern.

So, I sat with him. I listened. I assessed his understanding of heart failure and determined his priorities. We spent time making a plan. Later that day, he told me I was the first person to have ever explained heart failure to him.

Now, whether or not that was true, my thought was, "How can this be?" How could any patient who moves through our hospital system ever have that experience? What can we do better to make sure patients never experience poor outcomes because we as providers fail to do the work we need to do?

Limited health literacy is a national health crisis contributing to poor health outcomes. Decades of research exists outlining patient-level factors contributing to overall health literacy—low levels of educational attainment, poor numeracy aptitude, dependency and so on.

However, less research has been completed to find targeted interventions to address these issues. It is becoming clear that efforts to improve the health literacy of Americans hinges on provider interventions to address this social determinant of health.

But are inpatient nurses prepared to tackle this challenge? I set out to find the answer.

My doctor of nursing practice (DNP) project, which began in 2019, sought to reveal the importance of equipping staff nurses with the skills and resources essential to the care of inpatients with low health literacy. First, I designed a survey to evaluate staff nurse knowledge, skill and attitudes towards health literacy.

Despite demonstrating proficiency in most health literacy concepts, staff nurses lack clinical skills and resources to effectively identify patients with low health literacy and address their unique needs. I also found staff members ambivalent about their roles as patient education providers.

From there, I coordinated a pilot of a validated health literacy-screening tool. In a one-month, pre-pandemic pilot, more than 57% of patients admitted to acute care medical and surgical units were identified as having inadequate health literacy. These findings underscored the importance of staff preparation since such a large volume of inpatients experience low health literacy.

Finally, I synthesized best practices into a health literacy algorithm designed to guide staff nurses in the care of patients with low health literacy. It serves as a competency guideline designed specifically to integrate with the current electronic medical record. The information is highly transferrable and could be adjusted to a variety of clinical settings

This project has demonstrated the need for professional preparation of staff nurses with clinical skills essential to care for patients with limited health literacy. This preparation can start with raising awareness, but must include high fidelity communications training for front-line staff nurses. I believe I have ignited a desire in others to continue addressing the problems of poor health literacy with future health literacy initiatives. My project ended in the autumn of 2020. The project continues with another DNP student who will be expanding the project. ***– Denise Sanchez, MSN, RN, CCRN***

Integrating health equity into nursing

The COVID-19 pandemic put an abrupt and immediate halt to all in-person activities: lectures, clinical practice and professional development hours. The faculty swiftly adapted—using best practices in remote education derived from the Rush University College of Nursing's DNP online programs—and shifted all in-person lectures to remote learning. By Memorial Day 2020, a racial reckoning 400 years in the making commenced as students' awareness of systemic racism and its implications for patient morbidity and mortality increased following the police murder of George Floyd. While infectious disease experts at the Rush University Medical Center were able to implement measures to address the COVID-19 pandemic, the racial reckoning forced students and faculty to engage in deep self-reflection in response to the modern-day racist actions collectively experienced in America. Americans felt called to demand change through protests that started shortly after Memorial Day. Nursing principles of justice and beneficence called nursing faculty to move passive conversations of diversity and inclusion to actionable items of equity, justice and anti-racism. We invited students to several listening sessions as an opportunity to foster a sense of community, connect with wellness services and contribute to a plan of action, which included:

- Strengthening recruitment and retention initiatives of students and faculty systemically underrepresented in nursing;
- Eliminating race-based medical teachings and incorporating bias-free language;
- Developing and implementing an anti-racist curriculum, which includes the history of white supremacy, race and racism, an exploration of unconscious bias, and racial, gender and sexual orientation inequality, in addition to learning about critical race theory.

I join my colleagues and other university leaders in infusing anti-racist guiding principles into our university's mission and educational endeavors. ***– Monique Reed, PhD, RN***

Caring for the homeless during COVID-19

COVID-19 is a public health crisis superimposed on the already existing crisis of homelessness. An estimated 3.5 million people experience homelessness annually in the United States. Minorities are disproportionately affected. Experts predict homelessness will significantly increase due to massive global economic disruptions resulting from COVID-19 (Homelessness Research Institute, 2020; National Alliance to End Homelessness, 2020).

Homelessness is incompatible with health; COVID-19 is exacerbating that fact. The inability to maintain adequate

hygiene or a nutritious diet, combined with advanced physiologic age due to prolonged harsh living conditions, contribute to the disproportionate incidence of lung disease, heart disease, hypertension and cancer among the homeless. These are all risk factors for experiencing COVID-19's more severe and deadly symptoms, making this group disproportionately at risk and affected by COVID-19.

Compounding this issue, the shelters and social service systems supporting the homeless, already operating on very thin margins, have been critically strained by COVID-19. Many shelters are closed due to staff shortages or considered to have a high risk for the patrons who would sleep there. Many common places to find shelter and a bathroom, such as libraries, gyms and fast food restaurants, are closed, in addition to many soup kitchens and food pantries. Panhandling is less of an option due to decreased foot and auto traffic. In addition, strained medical systems are anxious to discharge patients not needing hospitalization for recovery from COVID-19 to create space for more critically ill COVID-19 patients. Yet homeless individuals do not have a place to recover and complete their quarantine time, and shelters are unable to house them due to the outbreak risk in congregate living settings.

To address this issue, the Chicago Department of Public Health, the Mayor's Office, and A Safe Haven Foundation partnered with Rush University College of Nursing's faculty practice to open a COVID-19 shelter for persons with unstable housing to provide a safe space to isolate and recuperate. This project represents a critical public health solution to decrease COVID-19 spread among one of our city's most vulnerable populations.

Creating solutions for Chicago's people experiencing homelessness during the coronavirus pandemic felt like we were living in the zeitgeist of our time—dealing with critical issues of racism, inequality, injustice and public health all at once. I am humbled by and grateful for the dedication of my team and the city of Chicago, as we worked together to create this strategy on the fly with no playbook, with an ever-changing set of facts and circumstances. We continue to be proud to help our city and acknowledge there is more work to be done. To achieve health equity, nursing faculty must continue to remove policies and systems that have historically perpetuated racial inequities. ***– Angela Moss, PhD, APRN***

In closing, all nurses, regardless of position or practice setting, are needed to help mitigate the inequalities in health care and health outcomes. Nurses are well equipped to use their expertise and educational preparation to make a substantial difference through their nursing practice, research, education and advocacy endeavors. Rush nurses continue to answer this call to action. ◆

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Cultivating Diversity in Nursing Leadership: Role of the Sponsor

Ena Williams, MBA, RN, CNEP
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The call for increasing diversity in the nursing profession dates back for decades (Sullivan, 2004), including recommendations in the 2011 Institute of Medicine (IOM) *The Future of Nursing: Leading Change, Advancing Health* and its 2016 follow-up report. (National Academies of Science, Engineering and Medicine (NASEM)). The NASEM 2016 report indicated that if the recommendations of increasing diversity in the nursing workforce were to be successful, the nursing profession needs to focus its efforts on each level of the career trajectory. Figure 1 reflects the race and ethnicity of diversity in nursing from the U.S. Health Resources and Services Administration (2019) 2018 National Sample Survey of Registered Nurses compared to the 2019 U.S. Census Bureau population.

FIGURE 1: Race/Ethnicity RN Population Compared to U.S. Population

Race/Ethnicity	Nursing	US Population
Black Americans	7.8%	13.4%
Hispanic/Latino	10.2%	18.5%
Asian Americans	5.2%	5.9%
Native Americans	0.3%	1.3%

From all indications, the opportunity still exists to improve the racial and ethnic diversity of nurses in all levels of the nursing profession. A number of strategies can be employed by professional and organizational leaders to impact the diversity of nurses, especially those at the leadership levels. These strategies include mentorship, sponsorship, ensuring a supportive environment, availability of role models, structural changes, having a strong network and engaging in professional organizations (Beard & Julion, 2016; Beckwith et al., 2016; Morrison-Beedy et al., 2018). This article focuses on the emerging practice of sponsorship, a strategy organizational leaders are using to improve diversity in mid- and senior-level leadership roles.

Assuming sponsorship

The practice of mentorship is well-known and can greatly help the development of the early careerist. But when an individual wishes to enter the leadership sphere, a sponsor could prove more important than a mentor. Helms et al. (2016) noted that mentorship and sponsorship are different career relationship concepts. These authors assert that mentoring can take place at any level in the organization, with a focus on helping a person gain self-confidence in technical skills and knowledge of the organization, including emotional support and understanding political games. In contrast, Helms et al. (2016) describe sponsorship as going further to advocate for the career advancement employees (protégés) by giving them key assignments, exposure to essential decision-makers and protecting them from negative influence. Sponsorship has several advantages:

- development of a diverse leadership pipeline that is reflective of patient population;
- enhanced succession planning—participants already know the system, its policies and culture;
- development of dedicated leaders who are more likely to remain in the organization;
- communication of a sense of inclusivity in the workplace.

Sponsorship occurs when senior leaders in organizations provide opportunities for the individuals to be visible, thereby enhancing the competency and skill of the protégé, defined as an individual with leadership potential currently unknown or unrecognized by highly ranked leaders. Sponsors are influential senior-level members of the organization actively seeking to promote and widen the career opportunities of the protégé (Perry & Parikh, 2019). Sponsors work to get their protégés noticed by the "right people." The endorsement of senior leaders signals to the organization a level of trust and confidence in the protégé (Ng & Sears, 2020). The sponsor serves to enhance the visibility and credibility of talented individuals to other highly influential leaders. Therefore, a sponsor must be knowledgeable about the organization, the structure and the opportunities available inside or outside the organization.

Studies have indicated that sponsorship is one of the leading advantages of career progression among minorities (Beckwith et al., 2016), and is a recommended strategy in developing minority nurses (Sy et al., 2017). Sponsorship is of critical importance, especially in the middle to late years of a person's career, and can help to advance individuals into high-impact local or national leadership positions (Perry & Parikh, 2019). Figure 2 provides a functional role comparison of mentors and sponsors.

FIGURE 2: Mentor versus Sponsor Role Comparison

Mentor	Sponsor
Anyone	Senior Person
Person Focused	Career Focused
Advisor	Advocator
Builds Self-Esteem	Promotes Potential
Job Preparation	Provides Access
Sees Person as Mentee	Sees Person as Protégé
Performance Focused	Promotion Focused

Emerging trends

Senior nursing and organizational leaders are uniquely positioned to use their influence to provide new experiences and strategic exposure that would otherwise not be available to a protégé (Creta & Gross, 2020). A protégé can be identified through leadership performance, a succession planning program or the foresight of an organization preparing for leadership or structural change. The sponsorship process must be formalized with both the protégé and sponsor committed to the individual's development. Examples of strategic exposure include an assignment on a strategic committee, involving a nurse in a highly visible organizational initiative or providing funding to support educational and professional development.

Emerging examples of sponsorship models in health can be found in academic medical centers (practice) and in some master's in nursing administration programs (education).

Several hospitals and health systems have developed fellowship programs to develop future administrative leaders. Although these programs are similar in relative output, the program format is often unique to the health system. Hospital/health system fellowship programs (HHSFP) can be open or closed. An open program may recruit employees with a non-nursing or a nursing background, may or may not be degree specific, and available to both internal and external candidates. A closed HHSFP limits selection to only internal candidates, could exclude nurses and may require non-nursing graduate education. A few HHSFPs have separate programs for non-nursing administrative fellows and the department of nursing. In systems with dual programs, it is the responsibility of the senior nurse leader to ensure that nurse participant programs follow a sponsorship format. Employers also can send potential leaders to fellowship programs outside the organization for further development.

Sponsorship successes

One academic medical center in the Northeast uses a formal leadership development program for nurses at the director level to identify protégés based on a standardized assessment tool. A number of years ago, one of these nurses was assigned by the chief nursing officer (CNO) to a variety of assignments outside of her normal service role, which allowed for growth and development of knowledge, new skills, relationships and the protégé's visibility across the organization. One such assignment placed this ethnic minority nurse as a co-chair of the committee exploring the integration of nursing staffs while the organization was considering a hospital acquisition. After the hospital acquisition, this same nursing director was appointed by the CNO to the associate chief nursing officer (ACNO) role at the acquired site. This new role created an opportunity for the ACNO to work with the C-suite officers as part of a site integration team, which was comprised of the hospital president, chief medical officer, chief financial officer, chief integration officer and vice president of human resources. During the years this nurse leader served in the ACNO role, the CNO was continually realigning responsibilities and creating ongoing learning and exposure opportunities for the protégé based on identified gaps. Inclusive of the development of this ACNO was a recommendation by the CNO and hospital president to support the ACNO's participation in an external nurse executive fellowship program. After a number of years, the CNO retired and the ACNO was appointed by the hospital president to be senior vice president and CNO for the organization. This process allowed for the protégé to develop a number of skills such as executive presence, strategic thinking, strategic agility, communication skills and confidence. For this ethnic minority nurse, the endorsement and support from the CNO and other senior leaders communicated a level of trust and confidence in this person's ability to lead.

A nursing graduate administrative program in the Southeast was designed to use both mentorship and sponsorship to remove career barriers and promote career progression. The program is designed with administrative practicums that assign students to mid- and senior-level (C-suite) nursing and non-nursing preceptors. In addition, the students have field-based assignments. The practice-based preceptors engage with the student as a sponsor within the practicum site and the faculty function as the student's mentor and coach. To encourage the sponsorship role of

the preceptors, students are expected to work on key organizational projects and initiatives which place them in the presence of senior, influential leaders. Using this programmatic approach has led to many students obtaining their first leadership role and/or a promotion prior to graduation. For example, a current student was encouraged by senior leaders at the practicum site to apply for a director-level position, coached and provided a mock interview by the faculty. The student successfully competed for and accepted the position—just one of many students' promotions, proving the practicum format is working as intended to support career progression with a sponsorship model. Another student in another cohort shared that she was tapped for a promotion by a sponsor after working on a systemwide project.

Implications for practice

Phillips and Malone (2014) remind us that increasing ethnic minority diversity in health care positions could improve both the clinical outcomes and health status of the nation's vulnerable populations, positively affecting health disparities. Diversity in nursing leadership can also provide role models for other ethnic minorities to inspire them to join the nursing profession. It is imperative that the nursing profession moves from talking about diversity to actions that will create an equitable and inclusive work environment for all nurses. Diversity in leadership roles in education, practice, policy, administration and research is long overdue in nursing. The Sullivan Report (2004) provided three overlapping principles for moving forward: 1) change in culture of health professional schools; 2) exploration of new and nontraditional health professional paths; 3) and commitments to change at the highest level of institutional leadership. After the publication of the IOM *Future of Nursing* report, nursing made great progress with creating different pathways to accelerate entry into practice. However, the profession has been slow to address culture changes in practice and academia and to create a unified approach to help nurses reach leadership levels. Nurses have the power and tenacity to change this narrative, and it will require all our efforts and dedication to create this change. ◆

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Professional Pathways: Opening Doors for Men in Nursing

Demetrius J. Porche, DNS, PhD, FNP, FAAN
David Beasley, MHA, RN, NE-BC, FACHE

From 2002 to 2009 the nursing profession has grown by 62% (Macwilliams, 2013). Bowman (2020) reported that from 1960 to 2020 men in nursing increased from 2% to 13% of all U.S. nurses. The Bureau of Labor and Statistics reports a need for 3.19 million nurses by 2024. Men have historically been underrepresented in nursing, including roles in nursing education. With the increased demand for RNs, health care providers and academia must ensure an inclusive environment for everyone, no matter the gender. This article will explore the data on male nursing school enrollment and strategies to enhance recruitment of men into nursing. Also, this article includes the personal journey of one male nurse leader.

Nursing education

The challenge of recruiting and retaining a diverse population of men in the nursing profession begins in the nursing academic environment. According to the American Association of Colleges of Nursing (AACN) (2020a), during the period of August 1, 2018, to July 31, 2019, only 47,309 (12.7%) males were enrolled in undergraduate nursing programs. In graduate nursing programs during this time period, there were 17,608 (12%) males enrolled in master's, 4,993 (13.8%) enrolled in doctor of nursing practice (DNP), and 509 (11.1%) enrolled in a research-focused doctoral degree program. Of the graduates from August 1, 2018, to July 31, 2019, 18,308 males (12.7%) earned an undergraduate baccalaureate degree, 5,894 (11.8%) earned a master's degree, 1,043 (13.1%) earned a doctorate of nursing practice, and 79 (9.8%) earned a research-focused doctoral degree (AACN, 2020a).

The male nursing enrollment and graduation data may be reflective of the challenges reported by male nursing students. As a minority within the profession, Macwilliams and Bleich (2013) reported that male nursing students experience higher rates of attrition than female nursing students, experience higher levels of role strain, and loneliness and isolation (Macwilliams & Bleich, 2013). Researchers have identified barriers such as frequent references to "she" in lectures and textbooks; lack of male nurses in textbooks; little to no content on male contributions to the history and profession of nursing; gender-related bias in obstetric rotations; anti-male remarks made by nursing faculty and practicing nurses; and lack of male role models and mentors (Macwilliams & Bleich, 2013; O'Lynn, 2004). Male nursing students have expressed fear of "suspect touch" when caring for female nursing students, with little to no nursing content in lectures or textbooks addressing this. Negative influences on gender diversity in nursing are evident when nursing faculty place males under closer scrutiny, do not understand or accept the manner in which males engage in caring behaviors and express emotions or the ways in which men self-reflect on their practice. Men in nursing can be reluctant to seek support and sometimes engage in a less expressive form of self-reflection that may be assumed as non-caring by female colleagues. Men may be reluctant to engage in caring touch due to concerns about the touch being interpreted as inappropriate. In addition, faculty sometimes have the expectation that male nursing students should be assertive, act as leaders and take on the lifting tasks for the female students (Macwilliams & Bleich, 2013).

African American male nursing students experience similar challenges to white male students; however, some challenges are attributable to race. Patterson (2020) reported additional challenges experienced by African American male students such as being the only Black male in the class, clinical group or sometimes in the hospital setting (feelings of alienation, loneliness and social isolation), overcoming financial struggles, being excluded from study groups and social events, experiencing insensitive racial jokes and implicit biases, and lack of black male faculty.

Male academic faculty can experience a "glass ceiling" within the predominately female nursing academic environment. AACN (2020b) reports of the 783 nursing school deans in the country, only 46 (5.9%) are males. The largest number of male deans reported was in 2014, but that number amounted to only 6.2%. Male faculty also are underrepresented in nursing academia. Of the 21,622 faculty reported, 1,528 (7.1%) were male (AACN, 2020b).

Men in nursing academia have similar experiences to male nursing students. Male academic faculty report feeling isolated, desire more male role models in nursing academic administration and need mentors to assist with navigating the unfamiliar environment and culture of academia. Mott and Lee (2018) reported that male nursing faculty enter academia for the same reason as females—the desire to teach, motivated by the ability to shape the future of nursing. Male nursing faculty have a limited peer group and lack of male mentors to understand practices such as promotion, tenure and securing a program of scholarship and research. Male faculty also express concerns with interacting with female patients and female nursing students due to the "hidden thread of sexual conflicts" (Mott & Lee, 2018). Male faculty reported feeling the need to leave the door open when meeting alone with female nursing students. Male faculty experience unconscious and implicit gender bias within academia. Male nursing faculty report that differences in communication and the manner in which men think may not be appreciated for their diversity (Mott & Lee, 2018). Males may engage in a manner of direct communication that is succinct and expressive with minimal wording. This can be interpreted as aggressive communication by some individuals.

Recruiting men

Recommendations for recruitment of men in nursing:

1. Recruitment activities should begin prior to high school, as early as 8th grade.
2. Recruitment activities should occur in venues such as athletic events, community events and religious gatherings.
3. Junior high and high school guidance counselors should be educated about nursing as a male career opportunity.
4. Recruitment activities should also target parents and family members.
5. Health care organizations can create summer internship programs that expose males to the nursing profession.
6. Professions with higher unemployment rates should be targeted for second-degree candidates.
7. Alliances with military and veteran services can promote recruitment of military and veteran men.
8. Male nurse alumni of all male junior and high schools should be visible at recruitment events. ◆

A Journey to Nursing Leadership

My 14-year journey as a male RN will help shed light on the barriers faced by men in nursing; some are easily recognized, but need a robust collective effort to dramatically change. Growing up in the 1980s and 1990s in rural North Carolina, I did not see any men in nursing. In fact, my only interactions with nursing—the female school nurse and the female nurses who cared for my great-grandmother when she had a massive stroke—reinforced this image. At that time, momentum for equal rights for women was in focus. All-male military schools had to admit women in order to receive public funding; women were delaying marriage and children, pursuing higher education, joining the workforce, and assuming independence and identities outside of the home. This increased women's economic power and entry into male-dominated professions. By 1995, women reported earning half or more of the household income. The decades were rife with female pioneers: Sally Ride, Geraldine Ferraro, Janet Reno, Carly Fiorina and Madonna were trailblazing pathways for women (Yarrow, 2018). However, I did not see a corresponding movement for men to move into typically female-dominated careers. TV shows such as M*A*S*H, which had an all-male doctor and all-female nurse portrayal, gave way to shows like ER which had male and female doctors, but the nurses portrayed remained largely female.

Discovering nursing

Divine intervention led me to nursing. During my first career as an electrical journeyman, I found myself a single father of two children. I needed to stop traveling out of town to work, which led me back to college to be a teacher. First semester in Spanish 101, I met a male nursing student who opened my eyes to men in nursing. Despite strange looks from other men who heard I was going to be a nurse, I pushed forward because I knew I had found my purpose. I was fortunate to have three other men in my nursing class that made it to graduation. I was pleasantly surprised to find other males from similar backgrounds who had chosen nursing as a second career. Our books, the instructor's education style and projects were geared to a female audience as evidenced by references to the nurse as "she" or "her." In addition, only female references were made when discussing nurse engagement in provision of care. All the core faculty were female. Within our small group of male classmates, we felt no one else could truly understand our perspective on being a nurse.

Entering the nursing workforce as a male was exciting and intimidating. The experience created an empathy and support for those that deal with being a minority in other situations. My organization and work family were particularly supportive of my success. I tried every day to bring a strong work ethic, positive attitude and willingness to take on the most challenging assignments to rapidly improve my clinical skills. I transitioned the same mindset into leadership when given the chance, which led to my current director level position.

Continued on page 18

Challenges on the path

All along the way, my remarkable female colleagues helped open doors and push me to be the best I could be. I've had some great friendships with female colleagues that I would never replace. However, there were some that made me feel unwelcome to the field. When I pushed for challenging work, some of my supervisors placed me in assignments meant to sharpen and grow my clinical skills, while others placed me in assignments to take patients few female nurses wanted to care for. These assignments typically are behavioral health and/or patients with the greatest BMI. Male nurses I've met across multiple venues agree we want to take on more than our share of these patients, feeling a need to shield our female colleagues from the physical and mental burdens this type of patient can present. However, a constant stream of these patients can be draining. Professional relationships with female nursing colleagues also can be a challenge for male nurses. Rumors of romantic relationships can have traumatic effects on a male and female nurse who are a great work team.

As a supervisor I was concerned about being in a room with a woman alone. I had been warned early on to always keep the door open. When a female team member came to tears, my natural reaction was to place an arm on her shoulder. Early on, I spent a great deal of time just trying to figure out how to best console a female team member. It was very challenging. After much trial and error, I learned the best path forward was to be genuine, be mindful of personal space, and know your team members and their preferences.

Looking toward the future to meet nursing workforce demands, nursing must advocate for additional research in an effort to target, attract and retain male nurses. Local efforts are likely to influence young men to consider nursing as a career.

To my female nursing colleagues, thank you for all you have done to support men in nursing. You certainly are the pillars that gave nursing its foundation. Continue to push for nursing to be an inclusive profession. Be aware of what it feels like to be the only person of a different gender in the room. Seek to engage men in nursing in the improvement efforts in your units, facilities and organizations. We stand ready to help.

To my male nursing colleagues, thank you for having the courage to enter a female-dominated profession. Realize you are continuing to pave a path forward for the future of nursing. You are pioneers and can make a difference. Be a role model to other male nurses. Join a local nursing organization, partner with local schools and talk with students about what being a nurse means to you. Partner with schools of nursing to develop research and create changes in academia to support gender diversity in the art and science of patient care. Together we are stronger.

– David Beasley, MHA, RN, NE-BC, FACHE

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HOT TOPICS

Health System Council Spurs Nurse Participation in Advocacy

Catherine Skowronsky, MSN, APRN, ACNS-BC
Mary McLaughlin Davis, DNP, RN, NEA-BC
Summer Buckenmeyer, MSN, APRN, FNP-BC

According to the National Council of the State Boards of Nursing, more than 5 million RNs and LPNs are in the United States. That is significantly more than the 1 million licensed physicians. By contrast, 11 physicians but only 3 nurses were elected to the current U.S. Congress. This reflects the perceptions of some nurses that legislation is too complex to influence. At the Cleveland Clinic in Ohio, we took the approach of clarifying the process through education and mentoring nurses in a multihospital health system.

Cleveland Clinic's Nursing Institute has long supported nurses' engagement in the field of public health care policy. To that end, a Nursing Legislative and Health Policy Council (NLHPC) was established in 2014 with membership open to nurses across our health system. In addition, our APRN Council added an advocacy subcommittee in 2017 for further outreach to our APRN colleagues.

The membership and focus has changed through the years. The levels of involvement range from working on changing health policy on a local level to teaching nurses how to locate a state representative in order to practice advocacy on a national level. There is a strong benefit to educating, mentoring and developing nurses to expand their knowledge in the field of health care policy and practice.

Nurses first and foremost are patient advocates and our councils' members believe patient advocacy drives sound health care policy. The councils' successes in generating nurse involvement can be attributed to connecting nurses with issues they are passionate about. Both councils also educate on how nurses' desires to improve health for individuals and special populations and for their profession can be manifest through effective health care policy.

Over the history of our councils, we have held monthly meetings and ad hoc meetings, depending on the circumstances in our health care system. Many nurses are working and are students in a BSN, master's degree or doctorate programs. Schools of nursing have a strong focus on public health policy and this is how many of our members found their way to our councils. Many nurses are members of their professional organizations, which also have public health policy committees. The serendipity of belonging to dual committees makes the work easier and the impact greater for the issues our nurses are passionate about.

In pre-pandemic years, the NLHPC hosted the Annual Legislative Health Policy Conference inviting local, active council members, as well as nurses across our health system and the state, to witness how nurses use their tremendous influence to shape and humanize public health policy in our communities. Humanizing policy presentations included those covering human trafficking and the opioid crisis, which provided focus on these issues locally and their effects throughout Ohio. Another presentation came from one member who spoke about how she was able to update active shooter training at her son's high school by working with community leaders and the board of education. Sharing experiences on the local level proved our ability to promote and successfully change public policy.

Statehouse visits

For two years, our NLHPC organized a trip to Columbus for nurses at all levels of licensure to attend Nurses Day at the Statehouse, hosted by the Ohio Nurses Association. For many, it was their first opportunity to speak with their state representatives and senators face to face. In addition, our APRN Council arranged for a group of APRNs to attend APRN Day at the State House, hosted by Ohio Association of Advanced Practice Nurses (OAAPN), providing opportunities to talk with representatives

and senators on issues specific to Ohio APRN practice. One example is the need to provide patients with better access to care. To keep momentum during the pandemic, the APRN Council provided a virtual presentation to Cleveland Clinic nurses discussing how to advocate for the nursing profession. This included what advocating means and how to be involved, with the OAAPN president as guest speaker. To better advocate for our patients, we too have to advocate for our profession.

The Ohio Board of Nursing hosts virtual public hearings to provide safety and still support nurse engagement in matters that directly affect their nursing practice and patient care.

Tracking legislation

Ongoing work of our councils include monitoring legislation which would allow APRNs to care for a group of patients in a collaborative manner with physicians, but eliminate the need for a standard practice agreement to practice as a NP, clinical nurse specialist, nurse midwife or nurse anesthetist, following a set number of practice hours.

The councils also monitor Nurse Compact Senate Bill 341, which is another strong example of nurses advocating for nurses and ultimately for patients. If passed, this bill would give nurses the ability to work across state lines without the burden of multiple licenses, fees and continuing education requirements.

Our councils translate our passion into policy. They help nurses connect the dots between advocacy for patient care and nursing practice to provide the framework of health policy. As nurses change practice according to the best evidence, policy changes have occurred which continue to benefit the patients in our communities. Our councils also promote membership in state and national professional organizations to continue to be the voice of change. ◆

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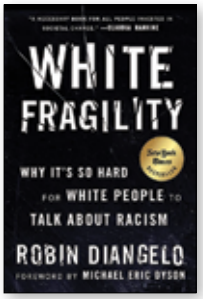
LeaderRead

Crystal Bennett, BSN, RN, CCRN, assistant patient service manager, Yale New Haven (Conn.) Hospital

Crystal Bennett read
White Fragility

By Robin DiAngelo



What I liked: This is a timely book that takes leaders on a journey of self-discovery with the goal of providing new perspectives around racial injustice and white privilege. Robin DiAngelo's detailed examples illustrate key concepts, such as aversive racism and white supremacy. She gives realistic approaches to real-life situations and guides readers in making meaningful change.

What I learned: Deeply rooted issues dating back centuries lay the groundwork for the racism individuals see in their personal and professional lives. In order to make societal change and move forward, leaders must take responsibility for asking questions, supporting all team members and opening a dialogue about race and inclusion. This journey starts with an examination of one's own implicit bias and a commitment to taking steps towards eliminating these prejudices.

Leadership Insight: As a leader, self-reflection and personal development are essential to guide a high-performing team that consistently feels respected, as well as engaged. Leaders must educate themselves in the history of racism in America and make committed steps towards change by becoming comfortable discussing race in the workplace. DiAngelo provides the background and motivation to help the leaders become more confident in steering and participating in these essential conversations.

If you have recently read a book that would be a fit for LeaderRead, please send your recommendation in this format to Terese Thrall, AONL managing editor, at **tthrall@aha.org**.

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AHA Events

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for the Commission are Ernest Grant, president, American Nurses Association; Alana Cueto, president, National Hispanic Nurses Association; Martha Dawson, president, National Black Nurses Associations; and Debra Toney, president, National Coalition of Ethnic Minority Nurse Associations. The work is currently focused on establishing a vision and mission. This will guide the creation of work groups in the areas of education, practice, policy and research to facilitate a deeper discussion into aspects of the profession.

In the wake of social and political changes, health care leaders have committed to improve and increase the diversity, equity and inclusivity of their workplaces. However, progress has been slow as organizations grapple with implementing efforts that encompass not just race and ethnicity but also gender, sexual orientation, culture and religion. There is no one approach for all organizations given the richness of diversity across communities. Here at Duke Health, we established a framework that we call Moments to Movement. This is Duke Health's collective stand against systemic racism and injustice. The name signifies going beyond passive moments of reflection and becoming more active as we build a movement to make lasting change for our patients, their loved ones and each other. It is a process of honest discussion and self-examination across all roles and disciplines to make our organization and our community stronger, healthier and more just.

We are confronting racism head-on because we recognize it as a public health crisis and a roadblock on our path to zero harm. We recognize that a healthier organization can only happen if all of us feel a strong sense of inclusion and belonging, so the first step in achieving our health system goals is to acknowledge those parts of our culture that need to change. That is the work of Moments to Movement.

As nurse leaders, we know that understanding and respecting one another is critical to delivering care that best meets patients' needs. In the spirit of focusing on solutions, this issue contains articles that provide context and ideas so you can start making positive changes in your own organization right now.

The article by Ena Williams and Martha Dawson focuses on the literature that can help us understand the background and challenges minority nurses face, as well as recommendations organizational leaders can adopt to support a diverse nursing leadership workforce. Their article highlights the importance of sponsorship as a method to create opportunities for diverse nurse leaders, particularly those in mid-career.

Jane Fitzsimmons and Angelleen Peters-Lewis focus on diversity in the C-suite. According to a 2020 report for McKinsey and Company and Leanin.org, women comprise 66% of health care entry-level positions, but only 30% of C-suite roles. Only 5% of those are held by women of color. The authors describe results of a survey designed to reveal barriers to career advancement and seven broad recommendations for promoting equity and inclusion.

Attracting more men into the nursing workforce has been a persistent challenge. Demetrius Porche and David Beasley's article provides much needed context on the state of men in nursing, including the data on males enrolled in nursing programs, their roles in academia and strategies for recruiting more males into the profession.

The remaining article comes from Rush Health System in Chicago, providing incredible accounts of efforts to reduce food insecurity, improve health literacy and a collaboration to address homelessness, all during the pandemic.

Finally, I would like to recognize the Honor Roll of Donors who support the AONL Foundation. Because of their generous support, we are achieving our mission of bridging science and education to shape the future of health care.

Thank you for all that you and your teams are doing to continue to care for all aspects of your communities. ◆

Leading Through Crisis Resources

Now more than ever, nurse leaders are invaluable to the teams, organizations and patients they serve. Their steadiness and calm help those around them keep perspective, and their vision and guidance can help bring out the best in their teams. AONL's Leading Through Crisis resources are designed to help nurse leaders bring out the best in their teams. Supported by an unrestricted educational grant from the Johnson & Johnson Foundation, this free compendium comprises online modules designed to help leaders employ effective strategies for coping, staying centered, building resilience and leading with integrity amidst challenging circumstances. To view the compendium, visit **aonl.org/resources/leading-through-crisis**.

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