Racial/Ethnic Diversity Management and Cultural Competency: The Case of Pennsylvania Hospitals

Robert Weech-Maldonado, Ph.D., assistant professor, department of health policy and administration, The Pennsylvania State University, University Park; Janice L. Dreachslin, Ph.D., associate professor of health policy and administration, Penn State Great Valley School of Graduate Professional Studies, Malvern; Kathryn H. Dansky, Ph.D., associate professor, department of health policy and administration, The Pennsylvania State University, University Park; Gita De Souza, Ph.D., assistant professor of business administration, Penn State-Delaware County Campus, Media; and Maria Gatto, health insurance specialist, Centers for Medicare and Medicaid Services, Chicago

EXECUTIVE SUMMARY

Major demographic trends are changing the face of America's labor pool, and healthcare managers increasingly face a scarcer and more diverse workforce. As a result, healthcare organizations (HCOs) must develop policies and practices aimed at recruiting, retaining, and managing a diverse workforce and must meet the demands of a more diverse patient population by providing culturally appropriate care and improving access to care for racial/ethnic minorities. Ultimately, the goal of managing diversity is to enhance workforce and customer satisfaction, to improve communication among members of the workforce, and to further improve organizational performance.

Research on diversity management practices in HCOs is scarce, providing few guidelines for practitioners. This study attempted to close that gap. Results show that hospitals in Pennsylvania have been relatively inactive with employing diversity management practices, and equal employment requirements are the main driver of diversity management policy. The number and scope of diversity management practices used were not influenced by organizational or market characteristics. The results suggest that hospitals need to adopt diversity management practices for their workforces and need to pay particular attention to marketing and service planning activities that meet the needs of a diverse patient population.

For more information on this article, contact Dr. Robert Weech-Maldonado at: *Rxw25@psu.edu.*

Diversity has become a crucial subject in the field of management as organizations pay increased attention to major demographic shifts in the U.S. population. As of 1999, 28 percent of the U.S. population was a member of a racial or ethnic minority group, and it is projected that by 2030, 40 percent of the U.S. population will be members of a racial or ethnic minority group (U.S. Census Bureau 1999). These changes are resulting in an increasingly diverse labor pool and customer base.

Policymakers are also being more attentive to racial/ethnic disparities in access to care and health status. While such disparities are well documented, relatively less is known about the underlying causes for the disparities. Researchers have examined financial barriers, racism and discrimination, and patient preferences as potential sources of these disparities (Williams and Rucker 2000).

To respond to the demographic shifts of the workforce and patient population and address racial/ethnic disparities in access and outcomes of care, healthcare organizations (HCOs) will need to become culturally competent organizations. Cultural competency has been defined as an "ongoing commitment or institutionalization of appropriate practice and policies for diverse populations" (Brach and Fraser 2000). While cultural competence is the goal, diversity management is the process leading to culturally competent organizations. Diversity management is "a strategically driven process" whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient populations (Svehla 1994).

Diversity management and leadership practices are known to enhance workforce and customer satisfaction, to improve communication among members of the workforce, and to further improve organizational performance (Cox 1994; Dreachslin 1996). However, only some organizations choose to respond to workforce and customer demographics by initiating diversity management practices and becoming diversity leaders (Dreachslin 1999). Others resist, making only those changes necessary to comply with affirmative action guidelines.

A recent survey on career attainment among healthcare executives across different races/ethnicities confirms that much improvement is still needed in the cultural and diversity climates of HCOs (De Anda et al. 1998). Research examining diversity management practices in HCOs is scarce. To date, only three prior studies have examined diversity management practices in HCOs—one using case study methodology (Muller and Haase 1994) and two others using survey methodology (Motwani, Hodge, and Crampton 1995; Wallace, Ermer, and Motshabi 1996). These studies have focused on human resources issues in diversity management. Each of the three studies found that relatively few hospitals had implemented diversity management programs even when hospitals considered diversity management an important organizational issue. Furthermore, Muller and Haase (1994) found that all hospitals in their study fitted the "pluralistic" profile in

which they were not actively managing diversity but employing diversity management policies and programs that were primarily compliance-oriented strategies.

This study addresses this gap in the literature by conducting a comprehensive assessment of diversity management practices covering both human resources and healthcare delivery issues. Within the context of hospitals in Pennsylvania, four research questions were investigated in this study:

1. What types of racial/ethnic diversity management policies and practices exist among hospitals?
2. What is the current status of racial/ethnic diversity leadership initiatives within hospitals?
3. What are the internal and external events influencing hospitals' racial/ethnic diversity initiatives?
4. What are the organizational and market factors that influence hospitals' responsiveness toward racial/ethnic diversity?

CONCEPTUAL FRAMEWORK

Based on case study research that documents the strategies and tactics of HCOs as diversity leaders, Dreachslin (1996) proposes a five-parts theoretical model for organizational change, from affirmative action to valuing diversity. The five stages in the model are:

1. Discovery: Emerging awareness of racial and ethnic diversity as a significant strategic issue
2. Assessment: Systematic evaluation of organizational climate and culture vis-à-vis racial and ethnic diversity
3. Exploration: Systematic training initiatives to improve the HCO's ability to effectively manage diversity
4. Transformation: Fundamental change in organizational practices, resulting in a culture and climate in which racial and ethnic diversity is valued
5. Revitalization: Renewal and expansion of racial and ethnic diversity initiatives to reward change agents and to include additional identity groups among the hospital's diversity initiatives

Each stage is characterized by different diversity management practices or behaviorally based performance indicators. HCOs are expected to be at different stages of Dreachslin's change process, and a natural progression is expected from one diversity stage to the other. For instance, organizations that score highest on Transformation are expected to score highly on the previous stages because they are more knowledgeable and more inclined toward diversity in the workplace on the whole. For a description of the performance indicators associated with each of these stages, see "Diversity and Organizational Transformation: Performance Indicators for Health Services Organizations" (Dreachslin 1999). Using the five-stages model, we hope to demonstrate the developmental process involved in diversity management as well as the relative importance of some practices over others.

METHODOLOGY

Sample

Senior management staff of 234 hospitals in Pennsylvania were surveyed by mail. The surveys were sent to the CEO of each hospital and to executives representing different functional disciplines within the hospital. Finance, nursing, operations, human resources, information systems, and quality improvement were among the functional disciplines represented by the survey respondents. The sampling frame was generated from the membership list of the Hospital & Healthsystem Association of Pennsylvania, a statewide organization that represents the interests of hospitals/healthcare systems throughout the state. The number of hospitals for which we received at least one completed survey was 203, which represented an 87 percent response rate.[1] Responses from all respondents in a given organization were averaged wherever applicable[2]; thus, we use the mean score of each item for each organization in our analysis.

Of the 203 hospitals, 92 percent of hospitals were not-for-profit, 5 percent were for-profit, and 3 percent were government-owned (VA); 84 percent of the hospitals were general medical facilities and 16 percent were specialty hospitals; and 75 percent were located in urban areas and 25 percent were rural facilities.[3] To determine the potential for response bias, t tests were performed comparing the mean characteristics of the respondent hospitals with those of the overall sample of hospitals in Pennsylvania. No significant differences were found between respondents and the overall sample for size, ownership, service type, location, or minority population.

Data

The main source of data for this study was a mail survey of Pennsylvania hospitals' diversity management practices. The survey implements Dreachslin's (1996) five-stages model that leads to effective diversity leadership and consists of performance indicators relating to diversity management policies and practices that are characteristic of each phase. The performance indicators used in the questionnaire were developed through a compilation of best practices in HCOs and in the corporate world (Dreachslin 1999). Business and health services literature, including both trade and academic publications, were reviewed to identify organizational practices associated with a positive diversity climate. Additionally, case studies of HCOs and executives were conducted to document best practices in detail. The studied HCOs and executives were identified through inquiries to organizational development consultants specializing in diversity as well as through press and trade journal publicity (Dreachslin 1996). A 5-point Likert-like scale (5 = strongly agree, 4 = agree, 3 = neither agree nor disagree, 2 = disagree, and 1 = strongly disagree) was used to assess the use of the different diversity management practices.[4] The survey was mailed during the period of March to July 2000.

The survey also included questions pertaining to the external and internal events influencing racial/ethnic diversity initiatives. The survey asked

respondents to rate the importance of these events on their racial/ethnic diversity initiatives on a 1 to 5 scale (1 = not important; 5 = very important). For example, respondents rated the importance of equal employment opportunity requirements in influencing their racial/ethnic diversity initiatives.

Other organizational and market characteristics, such as size, ownership, multihospital system membership, unemployment rate, and HMO penetration rate, were identified by using the 1999 AHA Annual Guide and the Area Resource File.

Scale Development

The survey items were factor analyzed, and seven factors were extracted that explained 57 percent of the variance. Reliability assessment using Cronbach alphas indicated that one scale had a low reliability; in addition, the scale lacked theoretical support, so it was dropped from the analysis. The resulting six diversity performance scales[5] included:

1. Planning scale
2. Stakeholder satisfaction scale
3. Diversity training scale
4. Human resources scale
5. Healthcare delivery scale
6. Organizational change scale

Table 1 shows the items in each diversity performance scale. Further information about the selection of the survey items can be obtained from the lead author.

Data Analysis

Research Question 1: What types of racial/ethnic diversity management policies and practices exist among hospitals?

We captured information on the types of diversity management practices by examining the means and percentages for each type of practice, as measured by the items in the survey. To determine the percentage of hospitals engaged in a given practice, scores of 0 and 1 (1= yes, 0= no) were calculated for each item. Responses of 1 to 3 on each item (strongly disagree, disagree, and neither agree nor disagree) were converted to 0, while 4 and 5 (agree and strongly agree) were converted to 1. In addition, a performance score was calculated for each diversity performance scale to assess the degree to which the practices and policies of a given scale are being performed:

Scale performance scores =
[(Sum of item scores) /
Total items in the scale]* 100

The performance score represents the percentage of practices of a given scale that an organization is performing.

Research Question 2: What is the current status of racial/ethnic diversity leadership initiatives within hospitals?

We assessed the status of diversity leadership of hospitals in Pennsylvania by developing a profile consisting of the six performance scores calculated above for the different diversity scales across hospitals. We also calculated the percentage of hospitals exercising high performance in each of the diversity performance scales. We defined high performance as a diversity performance

score greater than 50 for a given scale because that number signifies that a hospital exercises more than half of the practices in a given scale.

Research Question 3: What are the internal and external events influencing hospitals' racial/ethnic diversity initiatives?

We compared the means for the survey items pertaining to the external and internal events influencing racial/ethnic diversity initiatives to assess the relative importance of each event.

Research Question 4: What are the organizational and market factors that influence hospitals' responsiveness toward racial/ethnic diversity?

A diversity performance composite score was calculated that consisted of the average for all six diversity performance scores. We then examined whether hospitals differ in terms of their diversity performance composite scores based on organizational characteristics and market characteristics. Bi-variate analyses using t tests, ANOVA, and correlation analysis were conducted to assess whether the following organizational and market characteristics are associated with diversity leadership: size (number of staffed beds); ownership type (for-profit, not-for-profit, government); service type (general medical and surgical versus specialist hospital); membership in a multihospital system; urban location; minority population in the hospital county (1998 data); unemployment rate in hospital county (1998 data); HMO penetration rate in hospital county (1998 data); and per capita income in hospital county (1997 data).

RESULTS

Table 1 shows the means and percent of hospitals involved in each of the diversity management practices for each diversity performance scale. Wide variations in the level of involvement across practices can be observed. For the planning scale, having the strategic goal of equitable access and outcomes across all racial/ethnic groups had the highest participation (51.2 percent), while comparing the racial/ethnic demographics of the workforce by organizational level had the least participation (14.3 percent). For the stakeholder satisfaction scale, evaluating patient satisfaction data for all racial/ethnic groups served had the highest participation (33.5 percent), while communicating results of community satisfaction surveys to the community had the least participation (16.7 percent). For the diversity training scale, having a CEO who is enthusiastic and committed to diversity had the highest proportion (27.5 percent), while having external consultants train employees as diversity trainers had the lowest participation (5.9 percent).

For the human resources scale, identifying and supporting diverse employees with potential for advancement was the most favored practice (19.7 percent), while rewarding managers for meeting diversity goals was the least favored practice (4.9 percent). For the healthcare delivery scale, having patient information materials in languages other than English had the highest participation (41.8 percent),

while gathering epidemiological data on the relationship of race/ethnicity and primary prevention had the least participation (12.3 percent). For the organizational change scale, having racial/ethnic representation on the board had the highest involvement (25.1 percent), while rewarding change agents who spearheaded racial/ethnic diversity initiatives had the least involvement (2.9 percent).

Table 2 shows the means, performance scores, and the percent of hospitals with high performance (those with a performance score greater than 50) for each diversity performance scale. Hospitals had the highest performance score for the planning scale (27.65) and the lowest performance scores for the human resources (9.9) and organizational change scales (8.5). This means that hospitals on average were involved in 27.65 percent of the planning indicators, 9.9 percent of human resources activities, and 8.5 percent of the organizational change indicators. While 17.73 percent of hospitals had a score greater than 50 for the planning scale, only 7.88 percent had a score greater than 50 for human resources and 1.97 percent for the organizational change scale.

Table 3 shows the means for the internal and external events that may have influenced racial/ethnic diversity initiatives. While equal employment opportunity requirements were the most important factor, issues pertaining to crises, lawsuits, and negative publicity were the least important factor.

Statistical analysis showed that organizational characteristics (i.e., ownership, size, service type, and multihospital system membership) and market characteristics (i.e., urban location, percent of minority population, unemployment rate, managed care penetration, and per capita income) were not significantly related to the diversity performance score.

CONCLUSIONS/DISCUSSION

Dreachslin's (1996) five-stages model of diversity leadership provides a framework to assess the relative stage and strength of HCOs commitment to diversity management practices. The five stages in the model are: (1) discovery, (2) assessment, (3) exploration, (4) transformation, and (5) revitalization. The relationship of the diversity performance scales to Dreachslin's (1996) five-stages model is illustrated in Figure 1. Hospitals are expected to be at different stages of the continuum, and those hospitals considered to be at more advanced stages of the developmental process are expected to show high performance in earlier stages of diversity management as well.

As suggested by Dreachslin's (1999) framework, the degree of involvement in the different types of diversity management activities represents a progression for hospitals in Pennsylvania (see Table 2), with the highest performance score recorded for planning activities (27.65) and the lowest scores recorded for human resources activities (9.9) and organizational change (8.5) indicators. An interesting exception involves healthcare delivery, which has a higher performance score (25.18) than diversity training (15.67).

TABLE 1:
Mean Score and Percentage of Hospitals Involved in Diversity Management Activities, by Performance Indicator

Planning Indicators	Mean Score (s.d.)	Percent
1. The strategic plan emphasizes the goal of ensuring equitable access and comparable outcomes of care for all racial/ethnic groups in the service area.	3.79 (0.71)	51.2
2. Management openly acknowledges the need for training and development to effectively manage a racially/ethnically diverse workforce.	3.45 (0.77)	37.9
3. Information about the service area's current and projected racial/ethnic demographics is routinely gathered.	3.45 (0.70)	34.5
4. The strategic plan emphasizes the goal of recruiting and retaining a workforce representative of the service area's racial/ethnic demographics.	3.22 (0.79)	24.1
5. The racial/ethnic demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area.	3.15 (0.76)	23.6
6. Systematic reviews of services marketing and patient communication methods are conducted to evaluate the responsiveness to racial/ethnic diversity.	3.11 (0.69)	18.7
7. Systematic reviews of recruiting and staffing materials and methods are conducted to evaluate the responsiveness to racial/ethnic diversity.	3.04 (0.76)	16.7
8. Racial/ethnic demographics of the workforce are routinely compared by level (executive, management, professional, and service).	2.92 (0.71)	14.3
Stakeholder Satisfaction Indicators	**Mean (s.d.)**	**Percent**
1. Patient satisfaction is routinely evaluated and compared among all racial/ethnic groups served.	3.44 (0.88)	33.5
2. Community satisfaction is routinely evaluated among all racial/ethnic groups served.	3.39 (0.81)	30.5
3. Results of employee satisfaction surveys, including differences in perception among racial/ethnic groups, are openly communicated to employees.	3.21 (0.81)	25.1
4. Results of patient satisfaction surveys, including differences in perception between racial/ethnic groups, are openly communicated to employees.	3.24 (0.76)	24.6
5. Employee satisfaction is routinely evaluated and compared among all racial/ethnic groups.	3.14 (0.89)	24.2
6. Results of community satisfaction surveys, including differences in perception among racial/ethnic groups, are openly communicated to the community.	3.08 (0.70)	16.7

Table 1 (Continuation)

Diversity Training Indicators	Mean (s.d.)	Percent
1. The CEO speaks with enthusiasm and commitment to the organization's diversity agenda.	3.18 (0.81)	27.5
2. Diversity training is designed in response to systematic assessment of the racial/ethnic diversity climate and culture.	3.08 (0.77)	22.7
3. Non-clinical staff actively participates in diversity training.	3.02 (0.81)	21.7
4. Cultural competence training is provided to facilitate the delivery of culturally appropriate services.	3.15 (0.77)	21.7
5. Managers and other supervisors actively participate in diversity training.	2.95 (0.85)	19.7
6. Nurses and other caregivers actively participate in diversity training.	3.02 (0.80)	19.7
7. Executives actively participate in diversity training.	2.93 (0.82)	17.2
8. Diversity trainers emphasize the need for flexibility in the human resource practices in order to provide an equitable work climate for racially/ethnically diverse employees.	2.89 (0.83)	15.7
9. Diversity trainers emphasize the need for flexibility in the patient care practices in order to provide culturally appropriate service to different racial/ethnic groups.	2.82 (0.84)	14.8
10. Racial/ethnic diversity training is provided frequently.	2.75 (0.82)	12.3
11. External consultants provide diversity training and consultation.	2.45 (0.86)	11.8
12. A standing committee (task force, action council) monitors the racial/ethnic diversity climate.	2.40 (0.85)	8.4
13. Physicians actively participate in diversity training.	2.57 (0.75)	8.4
14. Resistance to racial/ethnic diversity training is openly discussed.	2.77 (0.68)	7.3
15. External consultants train employees who then serve as peer diversity trainers and advisers.	2.37 (0.76)	5.9
Human Resources Indicators	**Mean (s.d.)**	**Percent**
1. Racially/ethnically diverse employees with potential for advancement are systematically identified and supported.	3.13 (0.70)	19.7
2. Executive search firms are required to present a mix of candidates representative of the racial/ethnic diversity of the service area.	2.84 (0.70)	10.3
3. Prompt action is taken to address variances in the rate of job offers by race/ethnicity.	2.89 (0.71)	10.3
4. Corrective action is taken promptly when employee turnover ratios vary by race/ethnicity.	2.88 (0.71)	10.3
5. Prospective employees are interviewed by a team that is diverse by race/ethnicity.	2.75 (0.74)	9.8
6. Formal mentoring programs are emphasized.	2.80 (0.72)	9.8
7. Employee support, resource, or affinity groups for employees with shared interests and concerns (such as African-American or Hispanic groups) are formally sponsored.	2.59 (0.77)	9.8

Table 1 (Continuation)

8. Corrective action is taken promptly when the racial/ethnic composition of the workforce varies by organizational level.	2.81 (0.68)	9.4
9. Clinicians are rewarded for delivery of culturally appropriate care to racially/ethnically diverse patients.	2.86 (0.62)	8.4
10. Managers are rewarded for involvement in mentoring racially/ethnically diverse employees.	2.63 (0.68)	5.9
11. Executive and management compensation is based in part on achievement of racial/ethnic diversity goals.	2.43 (0.70)	4.9
Healthcare Delivery Indicators	**Mean (s.d.)**	**Percent**
1. Patient information materials are available in languages, other than English, that are spoken by significant numbers of community residents.	3.58 (0.73)	41.8
2. Prompt corrective action is taken when assessment results show an increase in the frequency and nature of complaints by racial/ethnic minorities.	3.57 (0.65)	35.9
3. Management talks openly about issues of race/ethnicity.	3.46 (0.71)	34.5
4. Activities to celebrate diverse racial/ethnic heritages are promoted.	3.62 (0.84)	27.1
5. Media that have a target market of racial/ethnic minorities are routinely picked for advertising efforts.	3.18 (0.68)	19.1
6. The relationship between race/ethnicity and secondary prevention (e.g., early detection through health screenings) in the service area is routinely gathered.	2.98 (0.78)	17.4
7. Changes to the organization's service mix are routinely implemented to better meet the needs and expectations of racial/ethnic minorities.	3.12 (0.61)	13.3
8. Information on the relationship between race/ethnicity and primary prevention (e.g., smoking, drinking, exercise habits) in the service area is routinely gathered.	2.92 (0.73)	12.3
Organizational Change Indicators	**Mean (s.d.)**	**Percent**
1. The board of trustees represents the racial/ethnic diversity of the community.	3.15 (0.81)	25.1
2. White employees are provided with opportunities to participate in conferences or work on project teams where people of color are in the majority.	2.98 (0.76)	15.8
3. Literacy, GED, English, or foreign language classes are offered at no charge to all employees.	2.38 (0.92)	8.9
4. Our organization receives media recognition for its positive approach to racial/ethnic diversity.	2.59 (0.69)	5.9
5. A new generation of change agents currently spearheads the racial/ethnic diversity initiatives.	2.63 (0.64)	3.4
6. Change agents who spearheaded the first racial/ethnic diversity initiatives in our organization have been promoted in part as a result of their efforts.	2.48 (0.65)	2.9

Table 1 (Continuation)

7. Change agents who spearheaded the first racial/ethnic diversity initiatives now mentor a new generation of change agents.	2.56 (0.66)	2.9
8. Change agents who spearheaded racial/ethnic diversity initiatives in our organization have received financial rewards for their efforts.	2.45 (0.65)	2.9

TABLE 2:
Performance Scores for the Diversity Performance Scales

Diversity Performance Scale	Performance Score* (s.d.)	% Hospitals Scoring > 50 (%)
Planning	27.65 (28.28)	17.73
Evaluation	25.78 (30.54)	14.78
Diversity training	15.67 (23.04)	14.29
Human resources	9.90 (18.98)	7.88
Healthcare delivery	25.18 (24.17)	11.33
Organizational change	8.50 (15.69)	1.97

* Range for all scales was 0 to 100.

TABLE 3:
External and Internal Influences on Racial/Ethnic Diversity Initiatives

	Mean (s.d.)
Equal employment opportunity requirements	3.80 (0.80)
Socially progressive individuals or groups in our organization	3.03 (0.91)
Publicity about other organizations' diversity practices	2.59 (0.89)
Crises, lawsuits, negative publicity in our organization	2.54 (1.08)

FIGURE 1:
Relationship of Diversity Performance Scales and Diversity Leadership Stages

Diversity Performance Scale	Diversity Leadership Stages				
	Discovery	Assessment	Exploration	Transformation	Revitalization
1. Planning	*	*	*	*	*
2. Stakeholder satisfaction		*	*	*	*
3. Diversity training			*	*	*
4. Human resources				*	*
5. Healthcare delivery				*	*
6. Organizational change					*

This may be a result of the pressures exerted on hospitals by government, the Joint Commission on Accreditation of Healthcare Organizations, hospital associations, and local communities to address the linguistic and cultural needs of patient populations.

Our results show that hospitals in Pennsylvania have been relatively inactive with respect to diversity management activities. This is consistent with previous research examining diversity management practices in the hospital industry (Muller and Haase 1994; Motwani, Hodge, and Crampton 1995; Wallace, Ermer, and Motshabi 1996). The level of hospital activity in diversity initiatives ranged from 27.65 percent of the planning indicators to 8.5 percent of the organizational change indicators. A similar picture is obtained when one examines diversity leadership. The percent of hospitals exhibiting high performance in the performance scales ranged from 17.73 percent for the planning scale to 1.97 percent for the organizational change scale.

The relative inactivity of hospitals in Pennsylvania with respect to diversity did not vary across different organizational (i.e., ownership, size, service type, and multihospital system membership) or market characteristics (i.e., urban location, percent of minority population, unemployment rate, managed care penetration, and per capita income). It was expected that larger hospitals located in more urban populations with a higher proportion of racial/ethnic minorities would be more involved in diversity activities. However, organizational and market characteristics were not found to have a significant effect on the composite scores for the diversity performance scales.

Hospitals considered equal employment requirements as the main driver behind their present diversity management activities. This suggests that most hospitals have been compliance-oriented as opposed to proactive regarding diversity management activities. Muller and Haase (1994) found similar results in their study of U.S. Southwestern hospitals.

The results of this study suggest that hospitals need to adopt diversity management best practices for their workforce. The study indicates four areas that merit special attention:

1. Establishing diversity training programs for clinical and staff personnel
2. Instituting human resources practices aimed at the recruitment and retention of minorities at all levels
3. Using structural mechanisms, such as a task force or quality improvement committee, to monitor the racial/ethnic diversity climate
4. Implementing control systems that reward management and clinicians for meeting diversity goals

Hospitals in Pennsylvania have been more active implementing healthcare delivery and patient care activities than actively involved with workforce issues. Nevertheless, the results show that relatively little is being done in this area as well since hospitals are only practicing 25.18 percent of the healthcare delivery performance indicators, and only 11.33 percent of hospitals are considered high performers

in this area. Furthermore, this study indicates that hospitals need to pay particular attention to marketing and service planning activities to ensure meeting the needs of a more diverse patient population. This should include developing culturally and linguistically appropriate services (RCCHC 1999).

Dreachslin (1999) has defined diversity leadership as being "responsive to demographic shifts and changing social attitudes among both the patients and the workforce." Increasing racial/ethnic diversity means that HCOs cannot continue doing business as usual, but they must respond with proper organizational initiatives that will accommodate the increasing diversity of their workforce and patient population. Those organizations that respond to the environment change are expected to perform better as their organizational strategy aligns with the requirements of their business environment.

Ultimately, organizations that successfully manage diversity will achieve competitive advantage (Cox 1994). A study by Covenant Investment Management attests to the financial benefits of diversity leadership in investor-owned corporations: Companies with strong track records in diversity management outperformed the Standard and Poor's 500 stock market average return on investment by 2.4 percent, while those with poor diversity performance underperformed the average return by 8 percent (Carfang 1993).

This study has provided important insight into the racial/ethnic diversity management practices of hospitals. However, this study was limited to Pennsylvania hospitals, and these hospitals may be unique in ways that limit generalizability to states with similar operating environments. Future research should replicate this study in other states, especially in those with a high proportion of racial/ethnic minorities. In addition, this study has valuable practical implications for healthcare management. To manage diversity effectively, HCOs will need to engage in human resources and healthcare delivery practices and policies aimed at recruiting, retaining, and managing a more diverse workforce and developing culturally appropriate systems of care. As Dr. Thomas C. Dolan, president and CEO of the American College of Healthcare Executives stated: "The time has come to ask ourselves some tough questions—about our actions and about those of our organizations. It is not enough to have policies promoting equal opportunity; we must ensure that current practices reflect those policies. And we must provide all staff with the training they need to work together for the benefit of our patients, members, or customers" (Dolan 1998).

Notes

1. The response rate at the executive level was 39 percent (533 out of 1366 executives originally surveyed).
2. The mean interrater reliability was 0.98 across all facilities (James, Demaree, and Wolf 1984).
3. Rural definition of county is based on a population more than 50 percent rural.
4. Information on construct validity of the survey can be obtained from the lead author.
5. The six scales showed reliability with Cronbach alphas, ranging from .94

(diversity training scale) to .80 (healthcare delivery scale).

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PRACTITIONER APPLICATION

Michael V. Ciccocioppo, Jr., FACHE, vice president, Compliance and Ethics, Holy Spirit Hospital, Harrisburg, and Martin J. Ciccocioppo, vice president, Research, The Hospital & Healthsystem Association of Pennsylvania, Harrisburg

The findings of the study presented in the article, *Racial/Ethnic Diversity Management and Cultural Competency: The Case of Pennsylvania Hospitals,* confirm what

we have observed over the past 15 years in Pennsylvania. This study shows us that affirmative action requirements alone do little to effectuate organizational culture change. Hospital cultures must come to value diversity as intrinsically good for the hospital and for the community. Internal champions who understand the critical need for change lead successful organizational change efforts. The fact that there is little activity in this area indicates that executives *personally* do not understand the value of diversity. A prerequisite for this larger organizational culture change to occur is for professional healthcare executives to *personally* experience the five stages of change described by the authors. The following are recommended practical activities that executives can do at each stage of their personal journey to understanding the value of diversity.

1. *Discovery.* Executives must become aware of the need to view racial and ethnic diversity as a significant strategic issue. They should thoroughly read this timely study and review many of the excellent references outlined at the end of the study.
2. *Assessment.* Executives must determine where their organizations are on the road to capitalizing on racial and ethnic diversity. The Tables in the article present a series of best practices against which an organization can benchmark its responsiveness to diversity practices. Another useful exercise during the assessment stage would be to determine what data their organizations have access to regarding the diversity of the population of the community they serve, their organization's patient demographics, and their organization's workforce.
3. *Exploration.* Executives must seek out opportunities to personally understand the need to expand opportunities for diverse potential leaders. They could attend conferences and seminars to get practical advice on how to foster diversity in management and workforce. They should network with executives from diverse racial and ethnic backgrounds and seek out employees, medical staff, and community members of diverse race and ethnicity and ask them for their perceptions of the organization and suggestions to move the organization forward.
4. *Transformation.* Executives can begin experimenting with various techniques to foster diversity within their own organizations. They could begin by identifying a couple of current employees of diverse race and ethnicity who appear to have potential for increased levels of responsibility and leadership and mentor them forward in their careers. They could serve as preceptors for diverse student interns and administrative residents in healthcare management. An additional benefit of helping launch and foster diverse individuals in their careers is that the preceptor would be exposed to the thinking and cultures of minorities and enhance their own understanding of the need for racial/ethnic diversity.
5. *Revitalization.* Once executives have personally moved from an affirmative action mentality to valuing diversity, they must take what they learned through

their change journey and become champions for diversity in their own organizations. It is only through their *personal* enthusiasm, experience, and confidence that their organizations will be able to effectively capitalize on the potential of diversity.

ADDITIONAL RESOURCES FOR PRACTITIONERS

The American College of Healthcare Executives's public policy statement, *Enhancing Minority Opportunities in Healthcare Management,* can serve as a guidepost to assessing current organizational efforts to improve racial and ethnic diversity. The College's professional policy statement, *Responsibility for Mentoring,* provides useful ideas on mentoring.

The Institute for Diversity in Health Management holds seminars for, and provides opportunities for networking with, healthcare executives from diverse racial and ethnic backgrounds. The Institute also has existing programs to help identify diverse student interns and administrative residents in healthcare management.