DIVERSITY IN EXECUTIVE HEALTHCARE LEADERSHIP: DOES IT MATTER? PERSPECTIVES AND IMPLICATIONS FOR ACCESS TO CARE BY PEOPLE OF COLOR

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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Public Health (DrPH) in the Department of Health Policy and Management in the School of Public Health.

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Abstract

REGINALD A. SILVER: Diversity in Executive Healthcare Leadership: Does it Matter? Perspectives and Implications for Access to Care by People of Color
(Under the direction of Ned Brooks, DrPH)

One third of the U. S. population belongs to an ethnic group other than non-Hispanic White and that population is growing increasingly diverse. People of color are increasingly accessing healthcare services, yet they represent less than one percent of healthcare leadership.

The primary purpose of this study is to address two key research questions:

1. What are the opinions and perceptions of White healthcare executives and executives of color regarding the race of healthcare executives and how it may affect access to care for people of color?

2. To what extent do White healthcare executives and healthcare executives of color vary in their opinions about how to improve access to healthcare for people of color?

This research is based on qualitative data obtained from interviews of key informants who are healthcare leaders in North Carolina and South Carolina. Informants were selected using a convenience sampling strategy. They were asked about their perspectives on the representation of people of color in executive healthcare leadership; what prevents people of color from obtaining senior leadership roles in greater numbers; and how the absence of people of color in senior leadership roles impacts access to healthcare services for people of color.
There was acknowledgement from informants that people of color are underrepresented in the most senior level healthcare leadership roles. Informants perceived that racial diversity on the executive leadership team can have a positive influence on access to healthcare by people of color. Informants believe that the race of healthcare executives can impact access to care by people of color. There is a prevailing perception among informants that the best way to improve access for people of color is through increased cultural competency.

There is congruity between elements highlighted in existing literature and responses from key informants about racial diversity, cultural competency, and the impact that diversity in executive healthcare leadership can have on access to healthcare by people of color. A number of strategies are presented to promote diversity in executive healthcare leadership as a way to ultimately improve access to healthcare.
Dedication

To Alvin and Glendora for putting me on the path

To Felicia for walking this path with me

To Alan for continuing to shine a light on the path

To Ayanna, Alijah, and Arianna, may you follow and find paths of your own
Acknowledgements

There are times when instead of finding the work we are searching for, the work that we are meant to do finds us. A better understanding of the phenomena associated with diversity in executive healthcare leadership has become nearly as much a personal pursuit for me as it has been an academic pursuit. As an engineering undergrad, I thought my dissertation would have something to do with an operational issue like emergency department overcrowding. Instead of studying management issues, this path has led me to writing a dissertation on a leadership topic that is an important issue of our time and, as indicated by the review of existing literature on the subject, an issue that is still understudied.

I am thankful for having had the opportunity to be accepted into a program which has provided me with the tools to better understand my evolution as a healthcare executive over the past sixteen years. The moments of success and the moments of frustration are much better understood now looking back retrospectively with the knowledge that I’ve gained from this journey. A better understanding of self, leads to a better understanding of the world around you.

I extend gratitude to my dissertation committee chair, Dr. Ned Brooks for his insight, guidance, and support to the study of a topic that has been controversial and understudied. I would also like to give a heartfelt “thank you” to the other members of my dissertation committee, Dr. Sandra Green, Dr. Suzanne Havala Hobbs, Dr. Michel Landry, and Dr.
Thomas Ricketts. I thank each of you for the support that you have given to me and to this work.

This work would have not been possible without the never-ending support of my family. I thank each of you for your support and encouragement during the long days and short nights. This research study is as much yours as it is mine. You were the inspiration and I was simply the scribe.

I would like to thank the key informants who gave me time out of their busy schedules to answer the interview questions written for this study. Without their participation and candor, this research project would not have been possible.

Thank you.
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List of Abbreviations

ACHE  American College of Healthcare Executives
AHEC  Area Health Education Center
CEO   Chief Executive Officer
CIO   Chief Information Officer
CMO   Chief Medical Officer
COO   Chief Operating Officer
DrPH  Doctor of Public Health
HEC   Healthcare Executive of Color
IFD   Institute for Diversity in Health Management
IOM   Institute of Medicine
IRB   Institutional Review Board
MPH   Master of Public Health
NAHSE National Association of Health Services Executives
NCHCAP North Carolina Health Careers Access Program
OMH   Office of Minority Health
WHE   White Healthcare Executive
Chapter 1: Background

The American population is growing increasingly diverse. The U. S. Census Bureau has reported that approximately twenty eight percent of the U. S. population belongs to an ethnic group other than non-Hispanic White [1].

Between 2000 and 2010, the fastest growth occurred in the Asian population (43.3%) and the Hispanic population (43.0%). The growth rate for Native Hawaiian and other Pacific Islanders was the third highest (35.4%). There was an eighteen percent increase in the American Indian and Alaskan Native population. The population increase among African Americans was approximately twelve percent. The lowest percent change in population occurred among Whites (5.7%). It is expected that this population shift will continue [2, 3]. The percentage distribution of the major racial groups is expected to follow these trends for the next forty years (Figure 1).

Figure 1. - Population Distribution Estimates by Race

<table>
<thead>
<tr>
<th>Racial Group</th>
<th>Percentage of Population in 2000</th>
<th>Percentage of Population in 2010</th>
<th>Projected Percentage of Population in 2050</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>75.10%</td>
<td>72.40%</td>
<td>74.00%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12.50%</td>
<td>16.30%</td>
<td>30.20%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>12.30%</td>
<td>12.60%</td>
<td>13.00%</td>
</tr>
<tr>
<td>Asian</td>
<td>3.60%</td>
<td>4.80%</td>
<td>7.80%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>0.90%</td>
<td>0.90%</td>
<td>1.20%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander</td>
<td>0.10%</td>
<td>0.20%</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

Note: 2000 and 2010 percentages were taken from The US Department of Commerce report “Overview of Race and Hispanic origin: 2010”. The 2050 projected percentages were taken from the US Census Bureau report “United States Population Projections 2000 to 2050”.
It is estimated that by 2050, the White population will make up a smaller percentage of the population than it does today. There will be explosive growth among Hispanics and other people of color.

There are two dynamic features of this population shift. The American population is growing larger and it is becoming increasingly diverse at the same time. However, this trend does not hold true in the administrative suites and boardrooms of healthcare organizations across America [4]. There has not been an equally dramatic increase in racial diversity within executive healthcare leadership roles. While the population continues to change, the racial composition of the leadership teams of governing bodies and policy-making entities remains predominantly male and predominantly White. This is true at almost every layer of the leadership strata. Executives of color are underrepresented in the c-level positions such as chief executive officer (CEO), chief operating officer (COO), chief information officer (CIO), and chief medical officer (CMO). Executives of color are also underrepresented in other healthcare executive leadership positions such as vice presidents, directors, and managers [5].

Although Asians, African Americans, and Hispanics comprise almost 30% of the population, they comprise less than 1% of the healthcare executive roles in the country [4]. A 2006 survey by Witt/Kieffer, a healthcare executive search firm, and Ohio State University’s School of Public Health revealed that of 844 health system CEOs, 84% were male and 96% were White [6]. There is also divergence between the diversity of healthcare executives and healthcare consumers as it relates to gender. The majority of healthcare executives are male, but the majority of healthcare decision makers are female. Starkey
pointed out that 75% of all healthcare purchasing decisions at the consumer level are made by women [7].

One of the premises of this research study is that the phenomenon of a high rate of increasing diversity in the American population and a slower rate of increasing diversity in executive healthcare leadership provides an opportunity to assess whether current healthcare leadership composition matches the needs of communities around the country. Specifically, do White healthcare executives view access to healthcare the same way as people of color? For the purposes of this study, the terms ‘people of color’ or ‘executives of color’ will be used to represent racial groups that have historically been viewed as minorities in the United States. Racial groups represented by these descriptors include African Americans, Native Americans, Asians, and all other racial groups that do not identify as being White.

The literature suggests that healthcare disparities exist between both racial and ethnic subgroups even when controlling for insurance status, income, age and severity of medical condition [8]. Could the underrepresentation of people of color in leadership roles within healthcare be a contributing factor to the existence of healthcare disparities? This question is based on a stream of thought that has emerged as it relates to the impact that the lack of diversity in healthcare provider roles has had on the propagation of healthcare disparities. In a briefing based on the US Institute of Medicine’s seminal report entitled “Unequal Treatment”, Nelson, et al. describe the negative effects that healthcare provider prejudice and bias can have on some patients¹. In another report, Schulman, et al. demonstrated how physicians were less likely to recommend cardiac catheterizations for African American

¹ The underlying assumption is that some healthcare providers may make at least some clinical decisions based on their own perceptions about a patient who belongs to a particular ethnic group, the patient’s socioeconomic status, or the patient’s ability to pay for treatment.
female patients who presented with identical symptoms as African American males, White males, and White females [9]. The study by Schulman, et al. suggests that a lack of diversity in healthcare provider roles can negatively impact the care that people of color receive by way of provider bias or prejudice. Similarly, a lack of diversity in executive healthcare leadership may be negatively impacting the care that people of color receive. This could be manifested in the kinds of policy being written as it relates to access to care across ethnic groups. The lack of diversity in executive healthcare leadership may also be contributing to the slow rate at which progressive healthcare reform policies for improving access to healthcare are being adopted. Healthcare leaders are a part of a representational community that can influence which interests are emphasized and put forward on a public platform [10].

The purpose of this study was to determine if there are differences between how White executives and executives of color view healthcare access. If differences of perspective exist between executives of color and White healthcare executives, then a case may be built for increasing diversity in executive healthcare leadership because a better understanding of the differences in perspective of White executives and executives of color might help to better match healthcare policy with the needs of a population that is growing increasingly diverse. Attempts at synchronization between policy and needs might result in an accumulation of knowledge that can be applied to solving issues of healthcare disparities and access.

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2 Peterson describes the representational community as the group of organized interests or institutions that are directly responsible for either translating proposals into policy or vetoing them.
Research Questions

This research study explored questions that speak to the rapidly increasing diversity of the population and the disparate rate at which diversity in the executive suites of healthcare organizations across the country has occurred. These questions are intended to add to the body of knowledge concerning racial diversity in executive healthcare leadership and how it may impact access to care for people of color. These questions may also lead to a better understanding of the policy making process that governs access to healthcare for people of color and how it is influenced by the homogeneity of decision-making groups. These questions may help to explain why sustainable healthcare reform to improve access to healthcare has been slow in arriving. One premise is that the rate of innovation has been hindered because there has been little representation of people of color within the decision-making bodies in healthcare. This might well explain why people of color continue to be disproportionately uninsured as compared to their White counterparts [11].

The two guiding research questions in this study were:

1. What are the opinions and perceptions of White healthcare executives and executives of color regarding the race of healthcare executives and how it may affect access to care for people of color?

2. To what extent do White healthcare executives and healthcare executives of color vary in their opinions about solutions for improving access to healthcare for people of color?

Should this study reveal that White healthcare executives and executives of color vary in their opinions about whether the race of healthcare executives matters in access to care by people of color, there may be the possibility that policies and practices have been misaligned in such a way that access to care by people of color is being negatively impacted. Such a
finding would also prompt a deeper look into why White healthcare executives and executives of color hold their respective opinions.

An equally important point is whether White executives and executives of color vary in their opinions about solutions that would improve access to healthcare for people of color. If it is determined that White executives and executives of color have very different views about how to improve access to healthcare for people of color, findings from this study may illustrate how some solutions for solving access issues may be missed if there is not a convergence of ideas and perspectives between the two subgroups.

**Objectives**

The objectives of this study were to:

1. Determine if views about healthcare access for people of color differ based on a person’s ethnicity and position as a healthcare leader

2. Create awareness of the absence of diversity in healthcare leadership roles by collecting demographic data from a convenience sample of healthcare leaders in a geographically bounded region of the United States

3. Inform researchers, practitioners, and policymakers about the impact that diversity in executive leadership may have on access to healthcare

4. Formulate an action plan to help organizations understand where they are at current state and provide healthcare leaders with tools to recruit, retain, and promote candidates of color
Chapter 2: Literature Review

Current literature on diversity in executive healthcare leadership roles is scarce. Much of the literature that is available is limited to the publications of professional societies such as the American College of Healthcare Executives (ACHE), the Institute for Diversity in Health Management (IFD) or the National Association of Health Services Executives (NAHSE) [12].

Other sources include healthcare trade journals that may or may not be peer reviewed. One can find a number of articles or white papers authored by journalists or consultants on the Internet. The scarcity of peer-reviewed literature on the subject illustrates the need for further research into the impact that a lack of diversity in executive healthcare leadership roles can have on access to care. Because of the scarcity of literature on diversity in executive healthcare leadership, literature about diversity in the healthcare workforce must often serve as a proxy. Parallels can be drawn from literature that illustrates how the mismatch between population diversity and healthcare workforce diversity has been demonstrated to impede the access to appropriate care by people of color.

The review of literature on the topic of diversity in executive healthcare leadership was conducted using three sources (Figure 2).
The first source of literature utilized was a combination of PubMed and Google Scholar. Search strings were used via Google Scholar as a means to rapidly search for relevant publication titles. When identified, these titles were located using PubMed and downloaded. The second and third sources of literature were Web of Science and a formal literature review conducted by a librarian from the Charlotte Area Health Education Center (AHEC).

Illustrating the scarcity of available literature on the subject, the search string “diversity in executive healthcare leadership” returned only 12 entries on PubMed. Of these 12 entries, five were substantially relevant to diversity in executive healthcare leadership. Multiple combinations of keywords and phrases were also used in an attempt to identify existing literature. As is typical within this genre of literature, there is a tendency toward focusing on the effects of diversity from the perspective of nursing or nursing leadership. Although these articles were excluded from this research project, the articles do present thematic constructs that are explored within this research project. The excluded literature delves into the underrepresentation of people of color in the overall healthcare workforce, the emerging study of cultural competency, and disparities in access to healthcare.
The inclusion criteria for this study limited articles to those that focused on diversity as a descriptor for a person’s racial or ethnic group or gender (male or female). PubMed articles that met the criteria for inclusion were reviewed to determine common themes.

When the search string “diversity in executive healthcare leadership” was used on Google Scholar, a total of 35,400 results were returned. The high number of results returned is misleading because the search engine behind Google Scholar focuses on each word in the search string individually. Google Scholar also focuses on open term searches which can influence the results that are returned. This produces results for ‘diversity’, ‘executive’, ‘healthcare’ and ‘leadership’. Google Scholar offers the option to search the most recent articles written. When this option is selected, the number of results returned is 16,300. Even though this significantly reduces the number of results to review, finding articles specifically about diversity in executive healthcare leadership is cumbersome. Articles that are retrieved have to be assessed for duplication and degree of relevance.

The search process on Google Scholar is a direct contrast to the same algorithm one would use on PubMed. PubMed will return a minimal number of results while Google Scholar will return an overwhelming number of results. The search process becomes a matter of using several permutations of the search string “diversity in executive healthcare leadership”. Results are returned highlighting the key words ‘diversity’, ‘executive’, ‘healthcare’, and ‘leadership’. There are very few results returned that tie all four keywords together. Results returned cover a broad spectrum of disciplines beyond the scope of healthcare and beyond the scope of diversity and executive leadership as defined in this research study.
Filtering the results for articles that have a high degree of relevance requires the identification of central themes that are related to the topic of diversity in executive leadership in healthcare. These themes are instrumental in not only categorizing available literature, but as they emerged from this research study, they became a methodology by which additional literature could be searched for and obtained. This type of relational search yielded three major themes that serve as the lens through which the absence of diversity in executive healthcare leadership roles could be viewed. The three major themes that will be developed in subsequent sections of this dissertation are cultural competency, the middle management plateau, and the importance of mentoring.

The third and final source of literature on diversity in executive healthcare leadership was a formal literature review conducted by a librarian on staff at the Charlotte AHEC. The librarian provided two searches in the Medline database and one search in the EBSCO Business Health database. In each search, the key words “diversity in healthcare leadership” were used. The librarian indicated that using additional search terms would have severely limited the search results from both databases.

The initial librarian-assisted Medline search was limited to case reports and reviews that spanned the time period from 1995 to 2011. There were 18 results found. Of these 18 results, only two entries bore relevance to the topic of diversity in executive healthcare leadership (Appendix 1). The two relevant studies from this collection of literature were authored by Dreachslin [13] and Motwani [14]. Dreachslin focuses on factors that affect the level of career attainment by women and people with diverse racial or ethnic identities within healthcare management. The study by Motwani represents an early attempt at understanding
how to better attract and manage more diverse talent during a time when it was thought that the genesis of a demographic shift in the workforce was taking place.

The second librarian-assisted Medline search spanned the time period from 2007 to 2011. The narrowed time parameter yielded 37 results. Of these 37 articles, 18 were included in the review and analysis of literature (Appendix 2). From these 18 articles that were considered for inclusion, three of them had already been cited previously in this literature review. It is noteworthy that only in the last five years has there been a significant increase in the amount of literature available on diversity in executive healthcare leadership.

The literature reviewed from this time period reinforces the major themes of cultural competency, the middle management plateau, and the importance of mentoring. Klein adds an additional level of significance to the impact that diversity can have on leadership. Her study points out that discrimination in the workplace still exists. To improve this, there is a need to understand both surface-level diversity (e.g., gender, race, ethnicity), and deep-level diversity (e.g., personality, attitudes, and values). Klein argues that surface level diversity may affect leadership opportunities, but deep-level diversity characteristics are the proper gauge for measuring leadership effectiveness [15]. While the Klein article focuses more on deep-level diversity, the brief acknowledgement that surface-level diversity could actually play a part in the selection process for leadership opportunities supports one of the central theories of this study. The current lack of diversity in executive healthcare leadership may be at least in part attributable to hiring decision-makers selecting those that they are most familiar with either through established relationships or through participation in social networks that are not inclusive of people of color.
There is a general sense from the literature that pursuing diversity within the ranks of healthcare leadership teams is the right thing to do. This is countered, however, by the fact that relatively few hospital CEO’s engage in any active planning process designed to improve diversity and diversity management [16]. In order for this to change, organizational leaders, including senior leaders must be fully invested in supporting diversity initiatives [16-19].

Developing a diverse and a culturally competent workforce should be an extension of the human resource recruiting function. When individuals who possess linguistic diversity are present in leadership positions, there is a significantly greater likelihood that they will recruit others who speak a language other than English, have leadership teams comprised of racially/ethnically diverse members, and there will be a close alignment with organizations that provide support to diverse groups of people [20]. The literature suggests that there is an implied link between linguistic competence and cultural competency. Services rendered to ethnically diverse groups might be improved by building components of linguistic and cultural competence into the curricula of healthcare management academic programs [21].

There is still a pervasive perception that there is a lack of diversity in executive healthcare leadership roles because there is a lack of candidates of color from which to recruit. In reality, people of color are being trained and developed but they are not transitioning to leadership opportunities at the same rate as their White male counterparts. The few candidates of color that do make the transition to leadership often do not stay [22]. This outmigration of talent may be partially explained by a lack of fully understanding the impact that leaders have on teams. There is emerging support from the literature to suggest that group leaders are likely to have an important impact on group diversity and the effect
that group diversity has on turnover. This is facilitated through the quality of the relationships that leaders develop with group members [23].

An additional factor that may explain the underrepresentation of people of color in executive healthcare leadership roles is applicable to leadership roles even beyond the scope of just healthcare. The decision-makers who determine the selection of candidates remain predominantly male and White. They may think differently about members of groups that have traditionally had limited access to leadership roles, often viewing their ability to lead as inferior. This would apply to women and members of minority groups based on race and ethnicity [24]. There is a natural tendency for hiring decision-makers to gravitate toward candidates that are most similar to themselves. Even when women and people of color are successful in obtaining executive leadership roles, their accomplishments are often devalued by the appraisers of their performance [25]. Both the non-selection of people of color and the devaluation of their contributions could be explained by unconscious attitudes toward racial and ethnic minorities, their leadership behavior, and the appraisals of their abilities to function in leadership roles [26].

Executive healthcare leadership positions are no different from other executive leadership positions in that they have been viewed and evaluated based on the contributions of White men who have predominantly held these positions of leadership. Chin and Sanchez-Hucles refer to this as the “great man” theory of leadership [27]. Perceptions about what successful leadership is have historically been based on stereotypes associated with White males. People of color and women who attempt take on leadership roles are often viewed through this lens.
As more attention has been called upon the underrepresentation of people of color in executive healthcare leadership roles, there has been an emergence of models and methods to understand the barriers that people of color face in obtaining executive leadership roles. There is also a growing body of knowledge that looks at the effect that absence of people of color in leadership roles may be having on the access to healthcare by people of color. Initiatives such as the Institute for Diversity in Health Management’s certificate program for diversity management in healthcare may be one way in which the representation of people of color in leadership roles may be increased [28]. Certificate programs and other diversity training opportunities made available to White executives and executives of color may provide a rich learning exchange from which leaders and organizations can increase their level of cultural competence.

The drivers that influence career attainment by people of color in the healthcare setting are comprised of social influences and human capital aspects. The social influences are comprised of widely shared attitudes, socioeconomic disparities and sociopolitical context. The human capital aspects include education and experience. Social factors are thought to be the more prevalent root cause as to why there is a career attainment barrier between women and people of color as compared to their White male counterparts [29].

The EBSCO Business Health database search yielded six new results when the same search terms were used (Appendix 3). Of these, two were relevant to the topic of diversity in executive healthcare leadership. From these studies, an article written by Armada and Hubbard reinforces three key points that were previously identified in this review of literature. The U. S. population is growing increasingly diverse and the healthcare needs of
this changing patient population are growing increasingly complex. Healthcare institutions will be challenged with providing culturally competent care in much the same way that Betancourt described organizational cultural competence, systemic cultural competence, and clinical cultural competence [18].

The other relevant work identified from the EBSCO search was produced by Olsen and presents an interview by an African American chief operating officer of Clarian Health. The article presents chief operating officer’s account of having dealt with racial discrimination while carrying out the duties of his executive healthcare leadership role. From these accounts, Olsen goes on to provide advice to organizations on how to combat this type of discrimination and promote diversity in leadership [30].

The three major themes that emerged from the review of literature are cultural competency, the middle management plateau, and the importance of mentorship (Figure 3). These themes were present in all three sources of the literature review.
These themes were developed by reviewing each work and noting areas of commonality. The state of existing literature appears to be focused to a higher degree on cultural competency.

Cultural Competency

The Office of Minority Health (OMH) defines cultural competency as an ability to assimilate linguistic, attitudinal, behavioral, and customary constructs across a number of different cultures in such a way that the healthcare provider can function effectively in meeting the needs of the healthcare consumer regardless of his or her ethnic background [31]. The OMH definition is borrowed from what is considered to be the earliest and most authoritative work on cultural competence, a report written by Cross, et al. in 1989 for
Georgetown University’s Childhood Development Center. Cross defines cultural competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables that system, agency, or professionals to work effectively in cross-cultural situations [32]. Olsen, et al. distill Cross’ definition of cultural competence into simply the ability to work effectively across cultures [33].

One of the contemporary thought leaders on diversity in healthcare management and cultural competency is Dreachslin. Dreachslin asserts that healthcare providers and organizations are culturally competent when they can illustrate a high degree of knowledge about other cultures and when they exhibit a high proficiency in communicating across intercultural lines [34].

Weech-Maldanado, et al. suggest that healthcare providers are obligated to respond to the demographic shifts in both the healthcare workforce and the patient population by becoming culturally competent. By illustrating diversity management principles, healthcare providers can improve employee and patient satisfaction while concurrently improving intercultural communication and organizational performance. Weech-Maldanado, et al. also assert that healthcare providers should become culturally competent as a means to improve racial and ethnic disparities in access to care and healthcare outcomes [35]. Weech-Maldanado, et al. were only able to identify three prior studies on the subject when they published their article on racial/ethnic diversity and cultural competency in 2002.

The relationship between cultural competency and diversity in executive healthcare leadership is important because, as Betancourt suggests, a lack of diversity in healthcare leadership is a barrier to culturally competent care [36]. Betancourt also suggests that there
is a connection between cultural competence, quality improvement, and the elimination of racial/ethnic disparities in care [36]. Taking Betancourt’s suggestion one step further, a high degree of cultural competence vis-à-vis a high degree of diversity in executive healthcare leadership roles may translate into improved outcomes such as improved access to healthcare by people of color.

Conversely, Betancourt warns that a failure by healthcare providers to understand the need for cultural competency could have a deleterious effect on people of color. Trust in the healthcare system and in healthcare providers is already low among people of color, particularly African Americans [37]. A low trust factor coupled with a low degree of cultural competency on the part of the healthcare system and healthcare providers means that there are serious barriers that prevent access to care for people of color.

Early on in the literature review, Dreachslin emerged as an authority on cultural competency. As the literature review continued to develop, there were two important works by Dreachslin that were found. In 1999, Dreachslin, et al. conducted a study on communication patterns and group composition. The goal of that study was to determine the effects that group diversity can have on communication patterns that in turn could have an effect on patient-centered care teams. Dreachslin suggests that workforce demographics in major metropolitan areas are strongly associated between roles in the patient care team and race [38]. Dreachslin noted that African Americans were more likely to perceive that race is a key component in communication breakdowns within patient care teams. Dreachslin also noted that Whites more frequently perceived race as a non-issue in the breakdown of communication in patient care teams.
In a second study conducted in 1999, Dreachslin outlined a five step process by which healthcare organizations could reposition themselves in their market space through diversity leadership. The steps in Dreachslin’s model are Discovery, Assessment, Exploration, Transformation, and Revitalization (Figure 4).

**Figure 4. - Dreachslin’s Five Step Process for Organizational Transformation**

<table>
<thead>
<tr>
<th>Process Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovery</td>
<td>Emerging awareness of racial and ethnic diversity as a significant strategic issue</td>
</tr>
<tr>
<td>Assessment</td>
<td>Systematic review of organizational climate and culture</td>
</tr>
<tr>
<td>Exploration</td>
<td>Systematic training initiatives to improve the organization’s ability to effectively manage diversity</td>
</tr>
<tr>
<td>Transformation</td>
<td>Fundamental change in organizational practices, resulting in a culture in which racial and ethnic diversity is valued</td>
</tr>
<tr>
<td>Revitalization</td>
<td>Renewal and expansion of racial and ethnic diversity initiatives to reward change agents and to include additional identity groups among the organization’s diversity initiatives</td>
</tr>
</tbody>
</table>

In addition to developing a model that could be used as a differentiation strategy or competitive advantage, Dreachslin informs the research community that cultural differences that affect both the decisions that guide healthcare consumption and patient satisfaction are strongly associated with race and ethnicity [39].

Gertner, et al. conducted a research study that complements Dreachslin’s five-step model. Gertner, et al. published a study that memorializes the transformative journey undertaken by LeHigh Valley Health Network as a response to several macro-level environmental factors. These environmental factors range from shifting population...
demographics and regulatory requirements to quality improvement initiatives and requirements for accreditation programs. The health system held a strategic planning retreat in which healthcare executives, physicians, other clinical staff, former patients and community members participated. In this session, patients indicated that they felt their cultural background, religious beliefs, and preferences for medical care were ignored or dismissed during the provision of healthcare services [40]. Gertner identifies this event as the spark that created the transformation that took place within the health system. The health system leadership enacted a series of cultural awareness projects based on a strategic plan that was developed as a direct result of the planning retreat.

Using Web of Science identified a commentary written by Rosenberg in 2008 that had been missed early on in the literature review. The focus of Rosenberg’s commentary was the lack of diversity in behavioral health leadership roles and how it impacted behavioral health services, particularly for people of color [41]. Two points from Rosenberg are relevant to this research study, 1) the population of behavioral health patients in the United States is growing increasingly diverse and 2) this increase of diversity is not seen in behavioral health leadership roles. These two points reflect two major premises of this current research study in exploring how these two phenomena are occurring in the larger healthcare space outside of behavioral health.

Rosenberg points out that there is disparity between how Whites and people of color view the representation of people of color in behavioral health leadership roles. Rosenberg cites the same 2006 Witt/Kieffer study that was cited by Vogues and referenced earlier in this review. In the Witt/Kieffer study, 80% of the people of color that were asked if they thought
that people of color were well represented on healthcare management teams disagreed. A significantly smaller percentage of White respondents disagreed. 59% of White respondents disagreed with the statement that people of color are well represented on healthcare management teams [42]. This finding suggests that there are differences between how Whites and people of color view the representation of people of color in healthcare leadership roles.

Other key findings from the Witt/Kieffer survey include perceptions between White respondents and people of color regarding the availability of opportunities for diversity leaders, reasons for committing to diversity recruiting, barriers to diversity recruitment, retention, and leadership development. The responses from White respondents and people of color remain considerably different when evaluated against these other criteria. White survey participants responded more often with favorable perceptions about improvement in opportunities for diversity leaders, the availability of diversity leadership positions and the availability of diversity leadership positions within their own institutions. People of color responded with consistently less favorable outlooks on each of these components of the survey.

Divergent responses between White respondents and people of color occur throughout the survey. A higher percentage of White respondents believed that diversity recruiting is a means by which organizational goals can be met, 63% agreed versus the 47% of people of color who agreed. Seventy percent of White respondents agreed with the notion that organizations undertake recruiting of diverse candidates because cultural differences support successful decision-making. Only 41% of people of color surveyed indicated that
they agreed. People of color were more likely to believe that barriers to diversity recruiting include lack of commitment, organizational resistance, and individual resistance to placing diversity candidates. White respondents were more likely to suggest that barriers to diversity recruitment include lack of diversity candidates to promote from within, lack of access to diversity candidates and, to a lesser degree, lack of commitment by top management.

Interestingly, the one facet of the study where responses from White respondents and people of color converged has to do with how diversity recruiting can be improved. 81% of White respondents and 80% of people of color who responded indicated that one way to improve diversity recruiting is through mentoring. Recall that the importance of mentoring was one of the three key themes that were developed in part one of this literature review.

The Witt/Kieffer study assessed the motivation behind why organizations undertake diversity recruiting. A later study conducted by Wilson-Stronks, et al. raised the question of what motivates hospitals to embrace cultural competence. This research question was positioned from the perspective of CEOs. The CEOs from 60 hospitals across the United States were interviewed. According to the results of these interviews, the main reason cited as to why hospitals embrace cultural competence is that doing so was instrumental in achieving the organizations’ missions or strategic plans [43]. Other, but less frequent, motivating factors for embracing cultural competence included meeting patient needs, laws, regulations, and to satisfy the requirements of external funding sources. The realization of perceived tangential benefits such as improved quality of care, increased market share, cost savings, and improvements in working environments were also considered as factors.
The Middle Management Plateau

In 2004, people of color comprised approximately 30% of the total number of graduates from healthcare management masters programs [12]. While this might seem like a significant increase in the number of potential candidates of color for executive roles, there has not been a significant increase in the number of candidates of color who have obtained roles above middle management. Voges notes that a number of employees of color with seven to twelve years of experience are unable to get past the level of director. Because so many employees of color become frustrated with not being able to transition from middle management into a senior executive role, a number of them decide to change jobs or leave healthcare altogether [6]. This might be one explanation why an increase in graduates of color has not translated into an increase in executives of color.

One of the seminal works on the career level achievements by people of color is a joint study that was conducted by ACHE and NAHSE in 1992. The purpose of the joint study was to illustrate the inequity of career attainment between African American healthcare executives and their White counterparts. The study was also developed with the intent of identifying factors that contribute to disparate career attainment between the two subgroups. As indicated in other studies, fewer African Americans held CEO positions or positions reporting directly to the CEO. Additionally, African American executives were compensated 13% less than their White counterparts, their job satisfaction was reportedly lower than that of their White counterparts, and African American executives tended to express less satisfaction with fringe benefits, job security, and respect from their peers [44]. These findings were noted even when levels of formal education between African American and White respondents were comparable and differences in years of experience were minimal.
The study was replicated in 1997 and it was expanded to include Hispanic and Asian healthcare executives. The 1997 study showed little improvement in career attainment for people of color.

An additional factor that respondents suggested as an explanation as to why so many people of color never make it beyond the middle management is because senior executives perceive that if they promote a person of color, they assume a greater degree of risk than if they promote a White candidate [44].

**The Importance of Mentoring**

Almost all of the literature reviewed in this research study highlights the importance of mentoring as it relates to progression from the middle management plateau into a more senior-level executive level role. There are two distinct ways in which mentoring is referenced in the literature. When mentoring is present, it is referenced as a facilitating mechanism that supports career progression. In situations where mentoring is not present, it is referenced as a root cause as to why many people of color are not able to obtain executive healthcare leadership roles. This dual reference is helpful in emphasizing how important mentoring is in aiding healthcare organizations increase cultural competence.

Mentoring is often mentioned in conjunction with succession planning. Succession planning appears to be poorly established among healthcare organizations. It appears to be comprised of informal social networks and the historical “good old boy network”, suggesting that career attainment is more predicated upon who a candidate knows instead of the credentials and experience that a candidate may have. This may be partially explained, as described by one respondent in the ACHE/NAHSE study, due to the differences in social networks that White professionals and professionals of color belong to. This respondent
noted that White professionals seem to have an advantage when it comes to social networks because they socialize where White executives socialize. The respondent noted that, by the same reasoning, minority professionals are disadvantaged because they are less likely to socialize in the places where White executives socialize. This creates a need for minority professionals to have to work harder to obtain the visibility needed to garner increased responsibilities [44].

**Synthesis**

The literature found during the literature search can be considered as a body of complimentary works. These works introduce to the research community the phenomenon of a population growing increasingly diverse while executive healthcare leadership roles are not. The importance of mentoring surfaces as a critical component in removing barriers that may be preventing people of color from attaining executive level positions. Conceptual frameworks of workforce diversity and cultural competency emerge in a way that organizations might become empowered to assess where they are at present state in relation to both diversity and cultural competence. These additional studies bolster the linkage between diversity and cultural competence. They also position both diversity and cultural competency as constructs for healthcare organizations to meet the challenges of a changing world and political landscape.

Of the three central themes that were identified in the literature review, cultural competency appears to be the most widely studied. Based on the articles reviewed, cultural competency appears to be inversely related to the middle management plateau, meaning where there is a middle management plateau, there are low levels of cultural competency. The literature also suggests that cultural competency exists at greater levels when mentoring
is present. In essence, a healthcare organization with a high degree of cultural competence tends to have structured programs and processes to eliminate the middle management plateau as the default level of maximum career attainment for executives of color. Such organizations have formal mentoring programs for professionals of color to assume executive leadership roles either by direct promotion or by promotion as a result of succession. These things alone, however, are not enough to effectively position cultural competence as a framework from which to improve access to healthcare for people of color.

In order to understand cultural competence as a framework to improve access to healthcare by people of color, one must acknowledge that a lack of diversity or low degree of cultural competence may create policies, procedures, and systems that are poorly designed to serve a diverse patient population [45]. The 2003 study conducted by Betancourt, et al. noted that there are organizational, structural, and clinical barriers to healthcare that contribute to inequalities of health outcomes among racial and ethnic groups. These barriers can also be thought of as constructs that exist when there is a lack of diversity in both executive healthcare leadership roles and the healthcare workforce in general (Figure 5).

**Figure 5. - Summary of Betancourt’s Constructs**

<table>
<thead>
<tr>
<th>Construct</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Barriers</td>
<td>• Underrepresentation of people of color in key healthcare leadership and policy-making roles</td>
</tr>
<tr>
<td>Structural Barriers</td>
<td>• A lack of interpreter services to facilitate episodes of care where the patient may be non-English speaking</td>
</tr>
<tr>
<td>Clinical Barriers</td>
<td>• An episode of care may be negatively influenced because the patient and the provider may have different cultural beliefs</td>
</tr>
</tbody>
</table>
These constructs have special relevance to this research study because they illustrate the barriers to healthcare access that a person of color is likely to encounter with an organization that has a low degree of cultural competence. Betancourt’s notion that these barriers to healthcare exist because of an underrepresentation of people of color in key healthcare leadership roles is a central premise to this research study.

Conceptual Framework: Diversity and Cultural Competence

Organizations that provide healthcare services can be viewed as having varying degrees of cultural competency and diversity in executive healthcare leadership. For conceptual purposes, these two dimensions were plotted together on a graph in which the level of diversity in executive healthcare leadership is represented on the x axis and the level of the organizational cultural competency is plotted on the y axis (Figure 6). The model can then be subdivided into four quadrants each representing high and low degrees of diversity combined with high and low degrees of cultural competency.
Organizations that can be classified in Quadrant 1 of the model exhibit a low degree of diversity and high degree of cultural competency. The conceptual model recognizes that cultural competency and diversity are two different constructs. It is possible, however unlikely, for an organization to have little diversity in its leadership and workforce but it may invest heavily in diversity training in an attempt to become more culturally competent. A pitfall for organizations in this category is the illusion of being able to buy into cultural
competency. Any gains achieved in this way are not sustainable because they are most likely the result of short-term training programs.

The literature reviewed on cultural competency suggests that obtaining sustained cultural competence is an evolutionary process that can only be supported by ensuring that the organization’s workforce is diverse and the cultural norms of its constituents are engrained in the management of the organization. In the healthcare setting, an example of this would be a community hospital with a diverse board of directors, a diverse senior executive team along with diverse management teams and staff. It is highly probable that an organization of this type would use community-based focus groups as part of its strategic development process. Organizations of this type are more likely to be found in Quadrant 2 of the conceptual model.

Quadrant 2 represents organizations that have a high degree of diversity and a high degree of culturally competency. These organizations focus heavily on developing a learning culture that embraces diversity. This would be evident by a diverse workforce throughout each echelon of the organization. This would also be evident by the absence or at least the minimal presence of the constructs that Betancourt defined. Quadrant 2 is the optimal position for organizations that are serious about diversity in the executive leadership ranks and cultural competency.

Betancourt’s constructs would be located in Quadrant 3 of the model. This is where organizations that have a low degree of diversity and a low degree of cultural competency would be classified. Organizations classified in this quadrant of the conceptual model tend to have almost completely homogenous executive leadership roles and an almost equally
homogenous workforce at the middle management, and staff levels. Organizational, structural, and clinical barriers are extremely prevalent for people of color when their healthcare needs take them to an organization that can be classified in Quadrant 3.

Quadrant 4 of the model represents organizations that have a high degree of diversity and a low degree of cultural competency. This would be representative of an organization with a diverse workforce but little investment in developing cultural competency. It is highly probable that Quadrant 4 organizations experience internal friction because group diversity is not managed in a concerted and conscientious manner. Cultural norms are more likely to override corporate objectives and strategy. This means that simply diversifying the executive leadership of a healthcare organization is not enough. Time, energy, and resources must go into helping to manage the idiosyncrasies that are inherent among different social and ethnic groups.

Limitations of the Literature Review

The existing literature on how diversity of top management teams affects the policy making process is inconclusive and remains an area for continued research. Arguments can be made from both vantage points of pro-diversity and pro-homogeneity. The arguments and counterarguments will only be resolved when there is a definitive study that firmly establishes the concept that a diverse team or organization outperforms a homogenous team or organization.

The search strings used in this literature review may have missed relevant works about diversity in executive healthcare leadership. While several permutations of the variables “diversity”, “executive”, “healthcare”, and “leadership” were used, it is possible that some works might have been published under subject headings other than diversity or
cultural competence. Works that may have offered relevant content but were published under the heading of social science, organizational development, conflict management, or some other topic were most likely missed during this literature search.

This literature review is primarily limited by the number of readily available studies on diversity in executive healthcare leadership. There is not a singular repository for published findings that articulate the impact that diversity in executive healthcare leadership can have on access to care.

An additional compounding factor is that relevant literature may have been missed in instances where the literature was not indexed properly from earlier years.

Significance of the Issue

The beliefs that healthcare executives hold regarding access to health care shape healthcare policy and ultimately determine many consumers’ level of access to healthcare. In order to improve access to healthcare, it is necessary for change agents to understand this relationship. This research study points to differences in how White healthcare executives and executives of color view access to care. In doing so, an important building block for future research and change is laid. Bridging the gap between people’s views regarding access to healthcare could be one of the missing links in sustainable healthcare reform.

Understanding the dynamics of diversity in executive healthcare leadership is an integral component of improving access to healthcare for a growing population that is becoming increasingly diverse and becoming simultaneously stratified as insured, underinsured, and uninsured.

A better understanding of these dynamics has the potential to improve access to healthcare for approximately 48.6 million people who are uninsured [46]. Because a higher
number of the uninsured population are people of color, change agents are going to have to develop higher degrees of cultural competency. Uninsured rates among people who identify as Black, Asian, or Hispanic, tend to be higher than those of their White counterparts (Figure 7).

**Figure 7. - Comparison of Uninsured Rates Among Major Racial Groups**

<table>
<thead>
<tr>
<th>Racial Group</th>
<th>Percent Uninsured in 2010</th>
<th>Percent Uninsured in 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>15.30%</td>
<td>14.90%</td>
</tr>
<tr>
<td>Black</td>
<td>20.80%</td>
<td>19.50%</td>
</tr>
<tr>
<td>Asian</td>
<td>18.40%</td>
<td>16.80%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>30.70%</td>
<td>30.10%</td>
</tr>
</tbody>
</table>


The plight of the uninsured illustrates the magnitude of the opportunity to improve access to healthcare. Millions of people are subject to health statuses that may be directly related to their socioeconomic status. A person of color is likely to wrestle with the challenges of accessing healthcare within a healthcare delivery system where the cost of an episode of care could mean deciding between getting needed treatment and paying other bills. The healthcare provider is more likely to be insensitive to the patient’s cultural norms or belief systems. Furthermore, the policies governing a person of color’s ability to access healthcare are more likely to be written by someone far removed from his or her own social circles. All of this lends special significance to the need to understand how a lack of diversity in executive healthcare leadership can translate into policy that does not meet the needs of a dynamically changing patient base.
In its 2003 report on the future of the public’s health, the Institute of Medicine (IOM) identified an underrepresentation of people of color in the public health workforce [47]. The report stated that the severity of this underrepresentation of people of color in the healthcare workforce has negatively affected access to care for people of color. It negatively affects the quality of care they receive when they access healthcare services. It negatively affects the level of confidence and trust that people of color have in the healthcare delivery system.

This finding gives further support to the theme developed from Betancourt’s work that the underrepresentation of people of color in the delivery portion of the healthcare continuum creates barriers for people of color in the access portion of the healthcare continuum.

Studying diversity in executive healthcare leadership will also add to the existing body of research that is currently available. Since Cross, et al. penned the term “cultural competence” in 1989, there has been little research on the effects that a lack of diversity can have on people’s views about access to healthcare.

**Implications for Future Research**

Future research could be conducted to determine what the optimal degrees of diversity and cultural competency for an organization might be. An analysis of diversity and cultural competency optimization, however, is beyond the scope of this research study. It is mentioned here as a placeholder for future research and as an acknowledgement of the counter position that an increase in diversity may lead to an increase in conflict among groups.

The effects of diversity on group performance have been studied by other researchers. These studies have often produced conflicting results. Some studies have indicated that
diverse groups perform as well as homogenous groups and may ultimately outperform them [48]. Other studies have shown that homogenous groups perform better than diverse groups because they do not have the inherent conflict that diverse groups have [49]. This position is predicated upon the lack of needing to manage opinions, beliefs, and other facets of diversity that may differ within the group.

On the surface, this stream of thought might suggest that the rate of innovation among homogenous groups is actually faster than that of diverse groups because barriers such as language, cultural norms and beliefs are not present. This stream of thought is problematic for two reasons. First, the material that is most readily available on the subject is somewhat dated with a number of the studies having been done in the late 1990’s. Secondly, these studies do not clearly refute that diversity has a positive impact on group performance. A good example of this is the study done by Knight, et al. in 1999. The study found that diversity within top management teams had negative effects on strategic consensus. In the same study, Knight, et al. acknowledged that individual members of top management teams might not perceive group processes in the same way due to differences in their individual experiences [50]. This actually supports the earlier point that increasing diversity to improve team performance is not enough; it must be fostered and managed. Cohen, et al. support the notion that this theme of improving diversity to improve team performance is especially relevant to the healthcare sector. They suggest that an increase in the number of minority health professionals in management and policy-making roles will help ensure that decisions about resource allocation and program design will be better fitted for a society that is growing increasingly diverse [51].
There is one area in which both streams of literature are in agreement. Whether the literature supports or refutes the idea that more diverse teams outperform teams that are less diverse, decisions made by diverse top management teams undergo a rich process in which the internal conflict of the team can be used to scrutinize the decisions made by the team [52]. This conflict can result in policy considerations that may otherwise be missed without added scrutiny from multiple points of view. This is a facet to the policy making process that can be inherently lost when the decision-making body is homogenous. This dissertation intends to make a number of contributions toward the development of future research topics. It places focus on the degree to which diversity in executive leadership teams and cultural competency can be optimized. This study provides an important conceptual model for healthcare organizations to be evaluated, either internally or externally, on how culturally competent they are. This study also serves as the bridge between existing research and future research that attempts to answer the question of whether more culturally competent organizations outperform organizations that have a low degree of cultural competence.

Timeliness of the Issue

For almost a century, healthcare reform has been a politically sensitive topic. There have been a number of attempts to improve access to healthcare through some variant of a national health insurance program. Attempts at national health insurance date back to 1915 with a proposal by the American Association for Labor Legislation, followed in the 1940s with the Wagner-Murray-Dingell proposal to expand Social Security, in 1965 with the passage of Medicare and Medicaid, in 1970 with the Health Security Program proposal, and in the 1990s with a proposal from the Clinton administration to the Affordable Care Act in 2010 [53].
Analysts continue to speculate about numerous reasons as to why such attempts at national health insurance have failed. Barriers to a national insurance program have included opposition from special interest groups, notably the American Medical Association (AMA). The AMA has been a major opponent of national health insurance programs since the attempt to organize health reform under the Roosevelt administration in the 1930s [54]. While the AMA supported much of the Affordable Care Act and did not oppose the Clinton efforts, the AMA has historically opposed initiatives when it deemed that such initiatives would restrict physician autonomy and physician compensation.

Barriers to a national insurance program have also been a product of intra-institutional conflict. Steinmo and Watts assert that attempts at national health insurance have failed so many times because of the inherent culture of the institutions that govern health policy. National health insurance has not been achieved because there is a high prevalence of individualistic political values that bias policy against initiatives that could be perceived as pro-statist or welfare oriented [55]. Opponents of national health insurance argue that a move toward a national health insurance program is a step toward socialism and a welfare state. This policy bias is magnified among institutions. Steinmo and Watts give some credence to the theory that national health insurance has not been accomplished because of opposition from interest groups. They also assert that this explanation is insufficient as it does not explain why some policy reforms have been successful and others have been unsuccessful. To understand why all previous attempts at national health insurance have failed, one must understand the influence that institutions have over perceptions about what can be achieved. In essence, national healthcare insurance has failed
because the institutions have not supported it in a way that has made people believe that achieving a national health insurance plan is feasible.

A common theme among these theories as to why national health insurance has failed is the need to manage the reactions of interest groups and institutions. Consistent with the current makeup of healthcare’s executive leadership, the leadership of these interest groups and institutions tends not to reflect the level of diversity found within the general populace. Could a focus on diversity in executive healthcare leadership have tangential benefits of managing interest group and institutional reaction to national healthcare insurance? This might be possible according to Steinmo & Watts. They raise the idea that opposition from interest groups and institutions might be mitigated through the process of those groups and institutions becoming more diverse. Could this course of study serve as a catalyst for sustainable change in light of the passage of a national healthcare reform initiative? Such questions illustrate the timeliness of this course of study in diversity in executive healthcare leadership and its implications for access to healthcare people of color. There has been a long history of missed attempts at healthcare reform and improvement in access to care. This course of study offers yet another explanation as to why these previous attempts at improving access to care have failed. The lack of diversity within the special interest groups and institutions that Steinmo & Watts reference in their study is symbolic of the very present issues of a lack of diversity within the executive leadership roles that can impact access to care at the community level.

With the passage of the Obama administration’s healthcare reform bill, the country is now poised more than it has ever been to extend access to healthcare services to millions of
Americans who either lack adequate coverage or have no healthcare coverage at all. The advent of this healthcare reform is an opportune time to study the effects that diversity in executive healthcare leadership can have on shaping access to healthcare services in communities across America.

The existing body of knowledge regarding diversity in executive healthcare leadership can be thought of as an emerging field of study. What can be gleaned from the literature to date is the following: 1) the U. S. population and the healthcare consumer base is growing increasingly diverse, 2) people of color remain underrepresented in executive healthcare leadership, 3) as the population grows more diverse, organizations must become more culturally competent, 4) the push for increased diversity must be championed by senior leadership, including the board of directors, and 5) mentoring will play a key role in the career attainment of people of color.
Chapter 3: Methods

This research study used a qualitative approach to data collection using a nonexperimental, descriptive study design. A qualitative approach allowed for the development of emerging themes from open-ended questions or image data [56].

The obtainment of data began with key informant selection, followed by key informant interviews and a qualitative analysis of the responses that they provided (Figure 8).

Figure 8. - Flow Diagram for Data Collection Methodology
Key Informant Selection

Key informants were selected from North Carolina and South Carolina. The dissertation committee suggested that informants be drawn from a geographically bounded area as a means to create a convenience sample. The convenience sample made the informant selection process manageable within a short timeframe.

Informants were identified by a combination of subject matter expert referrals, Internet searches, and from the primary author’s own professional network of healthcare professionals.

The subject matter experts who provided recommendations of informants to be interviewed included members of the dissertation committee and healthcare executives already known to the primary author. There were instances when an informant, who was not known to the author prior to the interviews, recommended another informant that he or she felt would make a good interview subject.

The Internet was used to locate healthcare executives that were not already known by either a subject matter expert or the primary author. The Internet was used to search for healthcare organizations across North Carolina and South Carolina. Websites were identified by searching for hospitals and healthcare systems in both states. Key words such as “NC hospitals” and “SC hospitals” were used with Google being the primary search engine. The websites of the respective hospital associations for both states provided hospital and health system directories that identified the major healthcare institutions in that state. The directories listed the senior executive officers for the institutions and provided phone numbers and email addresses for the executives. Healthcare executives were also identified through the use of LinkedIn, the professional networking website. LinkedIn provided easy
access to primary, secondary, and tertiary level contacts. Following the web of professional
contacts available through LinkedIn, the author identified a number of healthcare executives
that were willing to participate in the research study.

When the author had no preexisting relationship with a potential key informant, an
introductory email was sent to inquire about their interest in participating in the research
project (Appendix 4). Email addresses were obtained from the ACHE membership directory,
the North Carolina Hospital Association’s website, the South Carolina Hospital Association’s
website, and LinkedIn. When there was a preexisting relationship between the author and the
informant, the author contacted the informant by phone to solicit participation in the study.
A mutually agreeable time to conduct the formal phone interview was established and the
informants were called at the agreed upon time.

The author benefited from a personal network of health care executives that has been
developed over a seventeen year career in healthcare administration. A number of these
professional contacts still hold executive-level positions within North Carolina. The use of
existing contacts may have introduced selection bias and personal bias into this study. The
author attempted to mitigate selection bias when recruiting informants by emailing or calling
informants from an array of different institutions. The author also tried to enroll a higher
number of informants that were not previously known by the author. As a result of non-
responses, however, the informant pool was comprised of more informants with whom the
author had a preexisting relationship. The author attempted to mitigate personal bias by
asking informants to participate in the study regardless of how the author thought the
individual might answer the interview questions.
The key informant interviews were accomplished in approximately one month. Informants were enrolled from an array of healthcare institutions that included but were not limited to hospitals, healthcare systems, teaching and non-teaching medical centers, and multi-specialty physician groups.

The author initially thought that responses from healthcare executives of color would be limited because of the small level of diversity in healthcare leadership roles. To mitigate the problems that could have arisen from not being able to identify enough executives of color to participate in this research study, executives of color were identified first and then White healthcare executives employed at similar institutions were identified. This approach to key informant selection was advantageous because it ensured parity between the number of healthcare executives of color and the number of White healthcare executives participating in the research study. The concern over not being able to identify enough executives of color proved to be a non-issue because an equal number of key informants were found to represent the two groups.

There is no currently available demographic summary that would provide details about the ethnic identity of healthcare executives in North Carolina and South Carolina. Such information would have been invaluable in developing a formal sampling frame from which key informants could have been drawn.

This research study was not intended to provide an exhaustive search for key informants but rather it was intended to attract as many key informants as possible in a condensed timeframe. Although the interviews were conducted in a condensed timeframe,
this methodology lent itself to identifying elements to which current perceptions about
diversity and executive healthcare leadership can be ascribed.

A benefit of using interviews as opposed to other data collection methods was the
speed with which the interviews were able to be conducted. The interviews were also
beneficial from the standpoint that the interviewer did not have to directly observe the
informants to conduct the interview. Creswell identifies this as both an advantage and a
limitation to using interviews. While “remotely” interviewing candidates is advantageous, it
also precludes the ability to observe informants in their natural field settings [56]. The other
data collection types identified by Creswell would not have been practical for this study. The
other methodologies that Creswell identified were observations, documents, and audiovisual
materials [56]. Directly observing the informants in the field would have been both time
consuming and expensive due to travel requirements. The use of documents, assuming that
an appropriate number of documents were available, would not have provided an adequate
substitute for the perspectives gained from actually speaking with the informants.
Audiovisual materials would have also lacked the perspective gained from speaking with
informants.

**Key Informant Interviews**

Prior to conducting the key informant interviews, the author obtained ethics
approval from the Institutional Review Board (IRB) at the University of North Carolina at
Chapel Hill. The author also obtained verbal consent from informants using a telephone
script that was also reviewed by the IRB (Appendix 5).

A semi-structured interview was used to obtain responses from key informants. Key
informants were interviewed by telephone. The phone interviews were conducted using a
key informant interview questioning guide (Appendix 6). The interview questions were designed with input from a majority of the dissertation committee members during and after the dissertation proposal defense.

Key informants were asked to give their own perspectives about the diversity in their communities and whether they think that the makeup of their executive healthcare leadership teams was representative of the diversity found in their communities. Key informants were given the opportunity to recount any experiences that they had when they thought that diversity had a positive or negative influence on access to care or some policy related to access to care. These responses were documented and analyzed to develop common themes associated with each of the key informant groups interviewed in the study.

The ten questions that were asked of key informants follow the progression of how the executive entered into healthcare leadership, obtained his/her current leadership role, and their participation in social networks with other healthcare executives. The questions were designed to obtain responses that frame the importance of mentoring, whether selection for leadership is an openly competitive or biased system, and whether people of color are equally represented in executive healthcare leadership. The interviews were used to assess opinions about what the key informants deemed to be the greatest barriers to career progression in executive healthcare leadership. Key informants were asked to provide their perspectives on whether the level of diversity of the executive leadership teams of their organizations has an impact on access to care by people of color. The final question in the questioning guide dealt with whether informants think differently about how to improve healthcare disparities for people of color based on their own racial identities.
The design of the interview questions made it possible to develop codes and subcodes that were used to organize and analyze the responses from the informants (Figure 9). These codes and subcodes were necessary in order to analyze the data using qualitative data analysis software. MAXQDA (www.maxqda.com) was selected as the qualitative data analysis software for this research study. MAXQDA was selected because of its ease of use in importing text and organizing it for interpretation.
**Figure 9. - Interview Question Design and Codes**

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<thead>
<tr>
<th>Interview Question</th>
<th>Purpose</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell me what your role is?</td>
<td>Determine the appropriate leadership tier to classify the informant’s role in</td>
<td>Leadership Tier</td>
</tr>
<tr>
<td>2. How did you become a healthcare leader - what was your career path?</td>
<td>Gain perspective on how the informant entered healthcare leadership</td>
<td>Career Path</td>
</tr>
<tr>
<td>3. Describe how you were hired into your current role?</td>
<td>Understand whether the informant was hired or appointed to his or her current role</td>
<td>Current Role Attainment</td>
</tr>
<tr>
<td>4. To which professional societies or civic groups do you belong?</td>
<td>Identify the most popular professional societies or civic groups among informants.</td>
<td>Professional Societies and Civic Groups</td>
</tr>
<tr>
<td>a. Describe them.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. What are their purposes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. What is your role in each?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. What role did mentoring play in your career?</td>
<td>Determine the absence or presence of mentoring in the informants career trajectory and to determine the informants perspectives on mentoring</td>
<td>Mentoring</td>
</tr>
<tr>
<td>6. What is your view of the process of selection for executive level positions?</td>
<td>Gain informant perspectives about the nature of the selection process for executive leadership positions in healthcare</td>
<td>Views on Selection Process</td>
</tr>
<tr>
<td>a. How competitive is it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. How well do you think people of color are represented in healthcare leadership?</td>
<td>Determine informant perspectives on the representation of people of color in healthcare leadership</td>
<td>HEC Representation</td>
</tr>
<tr>
<td>a. Explain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. What would you say are the greatest barriers to career progression in healthcare leadership?</td>
<td>Identify the obstacles that informants think are barriers to career progression</td>
<td>Career Attainment Barriers</td>
</tr>
<tr>
<td>a. Would you say that these barriers are the same or different for candidates of color?</td>
<td>Determine if there are additional barriers for people of color</td>
<td></td>
</tr>
<tr>
<td>9. To what extent do you think that the level of diversity in executive healthcare leadership has an impact on access to healthcare by people of color?</td>
<td>Research Question 1: What are the opinions and perspectives of White healthcare executives and executives of color regarding the race of healthcare executives and how it may affect access to care for people of color?</td>
<td>Impact of Diversity on Access</td>
</tr>
<tr>
<td>a. Do you think that the race of healthcare executives matters when it comes to creating access to healthcare services for people of color?</td>
<td>Impact of Race of Executives on Access</td>
<td></td>
</tr>
<tr>
<td>10. What would your approach be for solving healthcare disparities, particularly for healthcare consumers or color?</td>
<td>Research Question 2: To what extent do White healthcare executives and executives of color vary in their opinions about solutions for improving access to healthcare for people of color?</td>
<td>Perspectives on Approaches to Solve Healthcare Disparities</td>
</tr>
</tbody>
</table>
Qualitative Data Analysis

Responses from key informant interviews were summarized in hand-written notes during the phone interviews. These hand-written notes were then typed into electronic documents that were imported into MAXQDA so that the data could be analyzed for common themes that evolved from the responses. Once the data was imported into MAXQDA, each document was reviewed and each section of each document was coded. The coding scheme that was developed represents the code system that MAXQDA utilizes to organize data for retrieval by specific codes or subcodes (Figure 10). The codes used represent topics from the literature review as well as topics that emerged specifically from the key informants.
Figure 10. - Code Browser Matrix
The code browser matrix function in MAXQDA was used to produce the above illustration of the codes and related subcodes that were used to group the text within each document. The circles on the code system diagram are arranged in columns. The columns represent the coded documents from each of the twenty four key informant interviews. The size of the circles on the diagram represent the amount of text associated with a specific coded response. A larger circle represents a greater amount of coded text for a certain response. The colors of the circles vary from blue to purple to red according to the size of the circles.

Responses were grouped according to key informant classification. Key Informant classifications were represented by acronyms coded to identify each respondent’s classification (Figure 11).

**Figure 11. - Key Informant Classifications**

<table>
<thead>
<tr>
<th>Acronym for Subgroup</th>
<th>Key Informant Classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHE</td>
<td>White Healthcare Executive</td>
</tr>
<tr>
<td>HEC</td>
<td>Healthcare Executive of Color</td>
</tr>
</tbody>
</table>

A benefit of conducting the analysis in this way was the ease with which it supported the development of themes from the responses about the attainment of executive healthcare leadership roles. This approach created an opportunity to illuminate elements in responses that related to three central themes from the literature review; cultural competency, the middle management plateau, and the importance of mentoring.

As a result of these themes emerging, and the identification of additional themes that are comparable across the key informant subgroups, a better understanding of the factors that contribute to the underrepresentation of people of color in executive healthcare leadership is
realized. This research project provided an opportunity to compare and contrast responses regarding how key informants from each subgroup would approach solving problems of poor healthcare access and healthcare disparities.

Project Timeline

Based on requisite approvals from the dissertation committee chair, the dissertation committee and the IRB, research commenced in July, 2012 with results published in January, 2013 (Figure 12).

Figure 12. - Project Timeline

<table>
<thead>
<tr>
<th>Task</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
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<tbody>
<tr>
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<tr>
<td>Proposal Revision</td>
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</tbody>
</table>
Chapter 4: Results

Of the 44 executives who were emailed or called, 24 were successfully contacted and interviewed. Reasons for non-participation by the 20 people who did not participate in the study are not known as they did not respond. The job titles of the responding and non-responding key informants were reviewed in order to determine if the study suffered from a lack of participation by the non-responding key informants (Figure 13).
Figure 13 - Details of Non-Respondents

<table>
<thead>
<tr>
<th>Non-Respondent Number</th>
<th>Referral Source</th>
<th>State</th>
<th>Organization Type</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Existing Relationship</td>
<td>NC</td>
<td>For Profit</td>
<td>Vice President</td>
</tr>
<tr>
<td>2</td>
<td>Existing Relationship</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>Vice President</td>
</tr>
<tr>
<td>3</td>
<td>Internet Search</td>
<td>SC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>4</td>
<td>Existing Relationship</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>5</td>
<td>Internet Search</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>President</td>
</tr>
<tr>
<td>6</td>
<td>Internet Search</td>
<td>SC</td>
<td>Not-For-Profit</td>
<td>President</td>
</tr>
<tr>
<td>7</td>
<td>Internet Search</td>
<td>SC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
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<td>8</td>
<td>Internet Search</td>
<td>SC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
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<td>9</td>
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<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
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<td>11</td>
<td>Internet Search</td>
<td>SC</td>
<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
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<td>12</td>
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<td>SC</td>
<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>13</td>
<td>Internet Search</td>
<td>SC</td>
<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>14</td>
<td>Internet Search</td>
<td>SC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>15</td>
<td>Internet Search</td>
<td>SC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>16</td>
<td>Internet Search</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>Executive Vice President</td>
</tr>
<tr>
<td>17</td>
<td>Internet Search</td>
<td>NC</td>
<td>For Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>18</td>
<td>Internet Search</td>
<td>NC</td>
<td>For Profit</td>
<td>CIO</td>
</tr>
<tr>
<td>19</td>
<td>Internet Search</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>CEO</td>
</tr>
<tr>
<td>20</td>
<td>Existing Relationship</td>
<td>NC</td>
<td>Not-For-Profit</td>
<td>Assistant Vice President</td>
</tr>
</tbody>
</table>

Had there been more participation from the non-respondents, there would have been a better representation of CEO’s and more representation of key informants from South Carolina. Because there were fewer informants from South Carolina, the results from the key informant interviews are heavily focused on the perspectives of executives from North Carolina.
Existing relationships proved to be the fastest way of accessing key informants to participate in the research. More than half of the informants interviewed were enrolled to participate in the study by way of existing relationships.

Other informants were reached through use of the Internet or personal contacts. The Internet search was conducted through the use of LinkedIn, the hospital directories found on the websites of the hospital associations in both North Carolina and South Carolina, and the online membership directory of American College of Healthcare Executives (ACHE).

The remaining key informants were identified through Subject Matter Expert referrals. This type of “snowball” sampling was reviewed by the IRB as part of the initial application process for this research study. Although there was not a large number of referrals from Subject Matter Experts, these referrals all resulted in the identification and enrollment of an informant into the study.

Descriptive data about the key informants who participated in the interviews were summarized in a tabular format (Figure 14).
Figure 14. - Key Informant Descriptive Data

Key Informant Representation by State

<table>
<thead>
<tr>
<th>State</th>
<th>Number of Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>NC</td>
<td>20</td>
</tr>
<tr>
<td>SC</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

Key Informants by Gender and Subgroup

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>Female</th>
<th>Male</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEC</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>WHE</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>12</td>
<td>24</td>
</tr>
</tbody>
</table>

Key Informant Places of Employment

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Number of Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-Profit</td>
<td>4</td>
</tr>
<tr>
<td>Not-For-Profit</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

Management Tiers

<table>
<thead>
<tr>
<th>Job Titles</th>
<th>Number of HECs</th>
<th>Number of WHEs</th>
<th>Totals</th>
<th>Management Tier</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>Tier 1</td>
</tr>
<tr>
<td>President</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>Tier 2</td>
</tr>
<tr>
<td>COO, CMO, CHRO</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>Tier 3</td>
</tr>
<tr>
<td>Associate COO, Vice President</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>Tier 4</td>
</tr>
<tr>
<td>Assistant Vice President, Director</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>Tier 5</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>12</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

Most of the key informants were from North Carolina. Women and men were equally represented; there were twelve women and twelve men who served as key informants. When stratified by subcategory of HEC or WHE, there were more women of color than men of color. There were also more White male healthcare executives than White female executives.
Twenty key informants are employed at not-for-profit institutions. Two academic medical centers, Wake Forest Baptist Medical Center, and UNC Medical Center, were represented. Both are not-for-profits. There were also four key informants who are employed in for-profit institutions.

Job titles included the positions of CEO, COO, and CMO. Some key informants held titles of President, Associate COO, Associate Vice President (AVP), Chief Human Resources Officer, Director, and Vice President. There was more representation of Presidents, Vice Presidents, and Directors than there was of other executive job titles.

There was overlap in the job responsibilities associated with job titles. Presidents may have been the senior executive of a hospital or a business entity within a larger corporate structure. Key Informants who held the title of President & CEO had dual responsibility as the senior executive for both a hospital and a larger health system. In some cases, the Director job title was closely aligned with the traditional COO role meaning that the person served as the senior operations executive for the institution. In other instances, the Director title was associated with responsibilities of service lines or particular business units. Within the Director job group, there was the widest variation of responsibilities and job duties. For the purpose of this study and the nuances within job classifications, the executive level is looked at as ranging from Director (lowest management tier) to President & CEO (highest management tier) with the other job titles falling in between.

When considering Tier 1 and Tier 2 as the most senior job titles, eight key informants are grouped into these two tiers. Of the eight key informants that hold the most senior executive positions represented in this study, only two are healthcare executives of color.
Both of these executives are currently operating in Tier 2 as presidents of hospitals. There are, at the time of this writing, no healthcare executives of color operating in the highest management tier in North Carolina or South Carolina.

Findings

Research Question 1: What are the opinions and perceptions of White healthcare executives and executives of color regarding the race of healthcare executives and how it may affect access to care for people of color?

Key Finding 1: Most informants believe that greater racial diversity on executive leadership teams can have a positive influence on guiding access to care by people of color.

The Impact of the Level of Diversity on Access to Care (Research Question 1)

Key informant responses were evaluated to determine perspectives about any potential effects of executive team leadership diversity on access to care for people of color. Responses were coded as ‘Diversity Impacts Access’, ‘Diversity Has No Impact on Access’, and ‘Noncommittal Answer’.

Twenty of the twenty four informants in this study indicated that they think that the level of racial diversity of a healthcare leadership team can have a positive impact on access to care for people of color. Informants suggested that this held true both in their respective organizations and in general. These responses were evenly balanced between the two informant subgroups.

Informants provided a number of examples of how they believe diversity on the executive leadership team can have an impact on access to care by people of color. One of the examples provided was the placement of outreach services. Informants suggested that a diverse team would be more sensitive to the placement of outreach services within
underserved communities even when the placement of such services lacked financial justification to do so. Informants also suggested that diversity on the leadership team might create a greater sense of awareness for healthcare disparities among different racial groups.

Two important perspectives emerged from the informants who believe that diversity on the executive team can have an impact on access to healthcare by people of color. Almost all of these informants believe that a more diverse team has a greater sensitivity to healthcare disparities. They also believe that a more racially diverse leadership team is able to connect more readily with a community in instances where the diversity of the leadership team reflects the diversity of the community being served. One informant stated that this is predicated on an inherent ability of people to know certain touch points within their own communities. These touch points can foster the building of trusting relationships between healthcare consumers and healthcare providers, facilitating the development of open channels of communication between the two stakeholder groups.

Another example of how community touch points can work, particularly in the African American community, was provided by a key informant who described outreach services and focus groups being developed in conjunction with members of the African American church. The church was cited multiple times by informants as a major institution within the African American community. Both White executives and executives of color acknowledge the need to connect with the African American church as a means of developing culturally competent access.

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3 For the purposes of this study, a touch point refers to any venue or gathering of community members within a specific racial group that provides easy access to members of that racial group. Examples of touch points that are frequently cited in the African American community are barber shops, salons, and the church.
The final example provided by informants regarding community touch points centered around a program in which blood pressure monitoring kits were placed in African American barber shops. The barber shop was cited as another major community touch point within the African American community in which efforts to improve disparities like hypertension could be focused on African American men.

Selected quotes from three HEC’s interviewed in the study illustrate how the themes of cultural competency and sensitivity to healthcare disparities began to emerge during the interviews.

“Healthcare executives have to cross ethnic boundaries. Cultural competency is required for successfully implementing an accountable care organization model. Patients participate in their own care. We participate in their care, so we need to understand their cultural backgrounds.” --- Key Informant A (HEC; President)

“White executives don’t see the impact. They don’t think they would do anything differently. When those in need don’t look like them, it’s difficult for them to reach out.” --- Key Informant B (HEC; Vice President)

“It does help to have diversity in leadership to recognize disparities among different ethnic groups. We have to have some level of commitment to patients of all backgrounds.” --- Key Informant C (HEC; President)

These perceptions were shared by three WHE’s who are similarly positioned in organizations.

“Huge impact. If you don’t reflect the people you serve that becomes the first barrier to healthcare. It’s hard to do outreach if we don’t look like the people we serve. It’s easier to improve access when you look like the community you serve.” --- Key Informant N (WHE, President/CEO)

“Great question. I think it can. If a healthcare organization wants to provide great care, it needs to understand the nuances of the cultures in that area of service. If the organization can’t understand those nuances, I have to believe it would impact care.” --- Key Informant W (WHE, President)

“There might be more empathy and awareness from an executive of color.” --- Key Informant U (WHE, President/CEO)

Informants perceived that racially diverse teams are more sensitive to disparities because people of color or someone significant to them are more likely to have been impacted by health disparities. In terms of how this direct or indirect exposure to a disparity
influences the leadership team dynamics, informants suggested that the disparity being addressed takes on a higher degree of importance when group members have had some personal, either direct or indirect, exposure to the disparity.

“In every community, there are healthcare disparities. When we look at disparities, we know touch points in our community. We can help organizations do this well; bridge the gap. It’s very, very important.” --- Key Informant J

“We have had issues come up at our management staff meetings that we, as a leadership team, were not sensitive to.” --- Key Informant X

There is more agreement than disagreement between the perceptions of HEC’s and WHE’s about racial diversity on the executive leadership team and how it can have a positive influence on access to care by people of color.

The prevailing perceptions are that a more racially diverse team is more likely to identify culturally competent tactics to solving disparities. These tactics include but are not limited to the placement of outreach services, the inclusion of community members in focus groups, and the identification of community touch points that can be used to leverage resources to expand outreach services.

Informants suggest that a more racially diverse executive team is also more likely to have constituent members who have had some direct or indirect exposure to a particular healthcare disparity. Such an occurrence brings a higher degree of relevance to the other group members because the member who may have been impacted by the disparity brings a name and a face to the problem that the group is trying to solve. By being able to speak from personal experience, the person impacted by the disparity can help other group members achieve a sense of urgency around that particular disparity.
Informant responses suggest that racially diverse executive leadership teams are able to “see” more than homogenous executive leadership teams. This enhanced vision applies to goal setting, creating a sense of urgency for particular issues, and heightened sensitivity to the cultural norms of the patient population being served.

**The Impact of Race on Access**

In addition to believing that diversity positively influences access to health care, the informants noted that the race of healthcare executives can also impact access to healthcare for people of color. Informants indicated that the perspectives of people of color in the design and access of their own care are important.

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**Key Finding 2: Key Informants believe that the race of healthcare executives can impact access to care by people of color.**

Responses build a case for the position that diversity in executive healthcare leadership is necessary to create programs and services that fit the needs of people of color. It is important that the leadership team resemble the diversity of the community that it serves for two reasons: 1) it promotes trust between the consumer and the institution and 2) it facilitates the crafting of policies that are sensitive to cultural needs. Quotes from two informants illustrate this perspective.

“We have to rebuild trust. People still remember Tuskegee. You have to get people to trust providers.”

--- Key Informant H

“There was a study that showed that an all White executive team came up with a policy that all visitors would have to leave a hospital at 5:00 pm. Each patient would be allowed no more than two visitors. This policy created havoc. When grandma is in the hospital, the whole family is usually there. You can’t make policy decisions in a culturally insensitive bubble.”

--- Key Informant L
White healthcare executives and executives of color both agreed that development of programs and services in a way that reach out to people of color have to incorporate the perspectives of people of color.

“I do think that if you have a CEO of color, he or she is more likely to pursue certain market segments even if they do not pay that well.” --- Key Informant E

“That’s interesting. I would suggest that it might. When I think about what I’m passionate about, veterans receiving access to care, improving healthcare, I realize each individual has unique life experiences or different experiences. It’s probably reasonable to think it matters.” --- Key Informant P

“I think a person of color could help solve some of our problems. That person would bring needed perspective.” --- Key Informant R

“Absolutely. I think if I’m going to talk at a historically black college or university, if I’m a Black leader representing our institution, people will pay more attention to what I’m saying. A level of appreciation will be more. We see a similar effect in our outreach programs” --- Key Informant X

Responses indicate a dual benefit to having racially diverse executives on the executive leadership team. There is a benefit to the institutions when a member of the executive team is part of a racial group for which the institution is trying to improve access. The executive of color serves as an ambassador who informants view as an agent for the interests of both the racial group and the institution. A repeated comment from informants who were President/CEO’s was that when approaching specific segments of the population it was important to have someone from that segment of the population be the spokesperson for the institution. This can be particularly impactful in instances where racial representation and proficiency in a non-English language are coupled together.

The second component to the dual benefit of having racially diverse executives on the executive team is predicated upon the linkage that informants assigned to diversity and culturally competent care. Informants perceive that community members will receive more culturally competent care when racial diversity exists on the executive leadership team.
Key Finding 1 highlights a perception that when a healthcare leadership team is racially diverse, it is more likely to be sensitive to healthcare disparities and it is more likely to identify and use community touch points in the delivery of care. Key Finding 2 highlights a perception that when people of color see their racial identity represented on the leadership team, they are more likely to have trust in healthcare delivery system and they are more likely to access healthcare services.

The four informants who stated they did not support the idea that the race of executives mattered in creating access to healthcare services for people of color indicated that diversity on the executive team is not necessary as long as the group is sensitive to the cultural nuances of the individuals that it serves. They suggested that this attainment of perspective comes through the use of open forums, focus groups, or other processes in which consumers of color are allowed to present to leaders what they believe their needs to be.

“I don’t think so. I’ve not experienced anything to make me believe that. When you are in a leadership position and you are designing services for a specific population, you have to be able to get insight into the belief and norms of that population segment (develop cultural competency).” --- Key Informant K

“No, I don’t think it matters. You don’t have to have a healthcare executive of color to create access. You do need to be able to get perspective.” --- Key Informant M

“What matters is what people see in the community. Racial diversity makes a difference on the front line, the provider, the person that touches the patient. It’s more important at the point of contact than at the senior leadership level.” --- Key Informant N

“No, you need people that are open-minded. I’ve met so many close-minded people of all races. There are so many other characteristics that drive a leader to be effective.” --- Key Informant W

Even among the responses from informants who believed that diversity and race of executives has no impact on access to healthcare, there was consensus that the perspectives of the people for whom access is being developed has to be obtained. Whether they agreed or disagreed that diversity can impact access to care, almost all the informants interviewed
indicated that cultural competency had to be somehow obtained when trying to address the issues of access and healthcare disparities.

**Research Question 2:** To What extent do White healthcare executives and executives of color vary in their opinions about solutions for improving access to healthcare for people of color?

**Key Finding 3:** Opinions of WHEs and HECs actually are in agreement across three domains: 1) cultural competency, 2) education and 3) healthcare reform.

**Perspectives on Solving Healthcare Disparities (Research Question 2)**

Informants said that they would approach solving healthcare disparities for people of color through cultural competency, education and healthcare reform.

The primary method for improving healthcare disparities was the development of cultural competency. The development of cultural competency at an organizational level as a way to improve disparities is not a unique idea. Informants did, however, associate the achievement of a greater degree of cultural competency with improving the representation of people of color within leadership roles.

“You have to get to know what the needs are. You have to be in and understand the community. We are comfortable with people that look like us and that we can relate to.” --- Key Informant F

“I would somehow get people to experience other cultures early in life to break down preconceived biases. It starts when you are young. You have to be exposed to other cultures and other ways of living. You have to experience it to shape future policy.” --- Key Informant S

Informants were careful to make the distinction between cultural competency and diversity. Responses suggested that merely increasing the level of diversity on the leadership team is not enough. In order to effectively address disparities, consideration has to be given to the cultural norms and beliefs of the healthcare consumer. Informants assigned a high
degree of importance to improving the representation of people of color in executive level roles and simultaneously increasing the level of cultural competency within leadership teams.

“Promote greater cultural awareness to promote an understanding that helps to explain why people access care differently or not at all.” --- Key Informant W

“I would have more team leaders of color go out and represent the services we have and market them to the community.” --- Key Informant X

“I would try to hear from representatives of these groups what their needs are and possible solutions. We are doing some of this now with outside support groups and focus groups.” --- Key Informant V

The secondary tactic for reducing healthcare disparities was education. Educational tactics were described in terms of services that promoted wellness and preventative behaviors among healthcare consumers of color. Within these responses, the African American church was again referenced as an important community touch point in the African American community. Informants suggested that educational offerings could be tailored for African Americans with the church being the venue for such offerings. This approach could be generalized for use with other groups of people of color. The idea is to take the educational programs and services to the places where people naturally go. Educational offerings at churches, community centers, and temples might prove effective in reaching Hispanic and Asian healthcare consumers.

There was a suggestion that education around wellness and healthy lifestyles should be focused specifically for students of color in elementary school and high school. By reaching students of color at earlier ages, healthy lifestyles, and preventative behaviors could be taught.

Informants stated that they felt that healthcare reform would force institutions to focus on healthcare disparities. Informants believed that healthcare reform, with its focus on
outcomes and quality measures, will drive organizations to target disparities to a higher degree than they have historically.

“With the new healthcare reform, everybody should get more access.”  --- Key Informant A

“Quality outcomes are forcing you to address disparities. If your scores or indicators are suffering because of a specific patient population, you are going to have to address the needs of that population. It’s quality improvement vs. disparities. People are more comfortable talking about it under the umbrella of quality improvement than disparities.”  --- Key Informant I

“Healthcare reform has created metrics that we will have to meet to show the results in our health system.”  --- Key Informant N

The informants who talked about healthcare reform in their interviews stated that they are proponents of National Health Insurance as a mechanism to combat healthcare disparities. These informants described a link between socio-economic status and healthcare disparities. From their perspective, the provision of National Health Insurance is one way in which to improve access to healthcare services for people that cannot afford private health insurance.

These informants stated that they hold the position that a patient should be seen for needed healthcare services regardless of the patient’s financial status and ability to pay for services rendered.

“I would say absolute, complete open access for everyone regardless of their ability to pay. There has to be some accountability from the individual; a healthy lifestyle, diet, being educated about the dangers of smoking. There would be a much improved state.”  --- Key Informant P

“It’s a problem in so many ways. I’m a proponent for healthcare reform. I support National Health Insurance. The solution is for all people to have an open access healthcare system. It’s a right.”  --- Key Informant U

Responses of healthcare executives of color and White executives both support healthcare reform and improving physician reimbursement as tactics to combat healthcare disparities. There is congruence of thought among the subgroups in terms of these two methods of approaching healthcare disparities.
There were areas in which a response type was unique to a particular subgroup. The tactic of using education to combat healthcare disparities was a unique response among executives of color. The use of lower copays as a means to improve access and the use of technology were also responses that were unique to executives of color (Figure 15).

Figure 15. - Solutions to Solving Disparities by Key Informant Subgroup

Cultural competency, healthcare reform and improving physician reimbursement were tactics that appeared in responses belonging to both subgroups. The revival and promotion of administrative residency programs was a tactic that only appeared in responses from White executives.

Figure 15 illustrates an important point. The middle portion of the diagram, the overlapping section of the ellipses, captures the tactics that were suggested by both White executives and executives of color. The outer portions of the diagram, the non-overlapping sections of the ellipses, capture the tactics that were unique to either subgroup. This diagram illustrates the importance of the diversity of the informants. Though difficult to prove, one has to give thought to the possibility that had these research questions only been asked of White executives, there is the possibility that the importance of education as a tactic to executives of color may have been missed. Similarly, had the questions only been posed to
executives of color, the tactic of revitalizing administrative fellowships as a means to increase diversity and ultimately impact access to care may have been missed.

Responses from both White executives and executives of color support the idea that diversity in executive healthcare leadership can positively influence access to care for people of color. Responses also support the idea that the race of healthcare executives impacts the creation of access to care for people of color.

Informant responses are in agreement across three domains, supporting an interrelationship between diversity, cultural competency and improved access to healthcare by people of color. This relational chain suggests that an indirect way to improve access to healthcare for people of color is by improving the level of cultural competency within institutions that provide care. The way in which cultural competency can be increased is through the expansion of diversity of the executive leadership team.

An important additional finding from this research study is the realization that executives of color and White executives agree on the impact that diversity can have on access to healthcare. They agree that diversity is difficult to achieve for a number of reasons. The design of the key informant interview questioning guide that was used to conduct the phone interviews lent itself to obtaining insight into how executives from both subgroups entered into the healthcare field. This research project has led to increased understanding of the barriers that create an underrepresentation of people of color in executive healthcare leadership roles. Institutions that successfully overcome the barriers to identifying, hiring, and retaining executives of color are well positioned to realize the benefits of increased diversity and the benefits that it brings to improving access to healthcare for people of color.
Key Informant Career Paths

In trying to understand how the informants involved in the study arrived at their current positions it is important to understand their point of entry into healthcare, their predisposition to healthcare leadership roles, and the circumstances around how they arrived at their current leadership role.

Additional Finding 1: WHE’s typically entered healthcare leadership in executive level roles. HEC’s typically entered healthcare leadership via clinical or technical roles.

Six distinct points of entry into healthcare leadership were identified by speaking to informants about how they entered into the healthcare sector. Informants entered the healthcare sector through technical roles, clinical roles, administrative residency programs, internships, managerial roles, or executive level roles.

Visual illustrations of the points of entry into healthcare leadership were developed to contrast the differences between the two subgroups (Figure 16). These models illustrate how key informant responses were coded and subcoded to identify themes centered around the career path by which the key informant became a healthcare leader (interview question 2).
Healthcare executives of color typically entered healthcare through a technical or clinical role. HEC’s also entered healthcare through an administrative residency program, internship or in one instance, a managerial role. There were no healthcare executives of color that entered healthcare directly into an executive level role.

The points of entry for White healthcare executives were distributed slightly differently. WHE’s entered the healthcare sector primarily at the executive level or by way of administrative residency programs.

Responses from informants about their career paths were coded to reflect whether or not the key informant providing the response had a predisposition4 to a healthcare leadership role. An informant was denoted as having a predisposition to healthcare leadership if the informant had a personal experience that prompted them to go into healthcare, held a non-leadership role in healthcare during the early part of their career, or had some other type of

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4 Throughout the results chapter, predisposition refers to exposure to healthcare leadership roles early in life.
exposure to healthcare leadership at some point in their development. The coded responses appear to be similar between HEC’s and WHE’s. Informants involved in this study typically had some predisposition to healthcare leadership.

Informants with a predisposition to healthcare leadership usually held a clinical role or entered healthcare through an administrative residency program. Two such informants remarked how their personal experiences involving the healthcare episodes of loved ones served as stimuli for them to seek out healthcare careers.

The informants that had no predisposition to healthcare leadership began their careers in other sectors external to healthcare. These sectors were business, the military, higher education, and manufacturing.

**Current Role Attainment**

When asked to describe how they were hired into their current leadership roles, informants from both subgroups acknowledge that there is both a formal and informal process. The formal process is predicated upon a job being posted then followed by an interview and selection process whereas the informal process is based on appointments to leadership positions and in some instances the utilization of unofficial networks.

*Additional Finding 2: WHE’s were more frequently appointed to their current roles when compared to HEC’s.*

Executives of color typically obtained their current positions through formal selection processes. There were instances in which an executive of color acknowledged that he or she had been appointed to the role without a position having been posted and a formal selection process conducted. WHE’s more frequently reported that they had been appointed or had access to an unofficial network of some kind.
The idea of an informal selection process that bridges part of the continuum between entry into healthcare and entry into one of the management tiers is an important perspective that emerged during the interviews of both subgroups (Figure 17).

**Figure 17. - Code Theory Model of Healthcare Executive Career Progression**

The informal selection process was described by informants as being reliant upon an unofficial network comprised of interpersonal relationships that either directly or indirectly influenced an outcome during some part of a selection process in their career. This influence was observed as occurring at either the point of entry into healthcare or during the transition into healthcare leadership by way of a formal or informal selection process.

Based on the coding schema used to organize key informant responses, this subtopic of unofficial networks was revealed to intersect with a number of other interview topics. When modeled with a minimum of five or more intersections, the topic of unofficial networks intersected with views on the selection process, current role attainment, career attainment barriers, and whether a person was appointed to their leadership position versus being hired or promoted into it (Figure 18).
Informants discussed unofficial networks most frequently in conjunction with ‘views on the selection process’ and ‘career attainment barriers’.

HEC’s often described unofficial networks in negative terms and as a huge barrier that needed to be overcome in order to attain a higher level leadership role.

“I have had to learn how to access unofficial networks that people of color are not invited to.” --- Key Informant A.

“Critical decision-making often occurs at social functions. Key decisions are often made on lunches, dinners, and golf courses.” --- Key Informant B.

“If you are not in certain circles, you will never get the shot at the opportunities you want.” --- Key Informant F.

“Probably one of the greatest barriers is breaking into the network at the highest levels of the organization. Some of these networks go back 20 - 30 years...” --- Key Informant G.

WHE’s described the existence of unofficial networks with less negative connotations. They described unofficial networks more as a means to an end; a natural part of the selection process. In some cases, WHE’s described themselves as having benefited
from the use of unofficial networks at some point during the selection process for a leadership role.

“I was working as a vice president for another health system. The CEO that hired me there came to work here. That same CEO approached me about this position. I interviewed through a recruiting firm and I was hired.” --- Key Informant R.

“A network of connections puts you on the radar already. I’ve had connections at different executive search firms. I still maintain relationships with them and with other executives that may have gone on to other roles and areas.” --- Key Informant S.

“In smaller systems, it is much more relationship oriented; relationships that you have built. This is true where I am now.” --- Key Informant V.

“Sometimes, it’s who you know and who recommends you. It’s about timing.” --- Key Informant X.

**Additional Finding 3: HEC’s view unofficial networks as career attainment barriers. WHE’s view unofficial networks in positive terms, as facilitating mechanisms for career attainment.**

A code relations diagram was developed to illustrate the frequency with which key informant descriptions of unofficial networks were associated with other topics (Figure 19).

**Figure 19. - Code Relations Diagram for Unofficial Networks**

<table>
<thead>
<tr>
<th>HEC Responses</th>
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<tbody>
<tr>
<td>Code System</td>
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<tr>
<td>----------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>WHE Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code System</td>
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<tr>
<td>----------------</td>
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</tbody>
</table>

The size of the squares on the diagram represents the relative strength of the association between topics. Larger squares on the diagram represent higher numbers of intersections between unofficial networks and the other codes.

There is similarity between the key informant subgroup responses in terms of the association of unofficial networks and their views about the selection process for executive healthcare leadership roles. Both subgroups describe unofficial networks as an inherent part
of the selection process and they do so almost to the same degree. WHE’s more frequently
described unofficial networks when they talked about the attainment of their current roles and
during instances when they described the informal selection process. Unofficial networks
were also associated with the topic of appointments versus hires or promotions. The
perspectives from HEC’s about unofficial networks diverged in almost every category except
in relation to views on selection processes. The most noticeable divergence occurred when
HEC’s discussed unofficial networks as career attainment barriers. HEC perspectives about
the relationship between unofficial networks and career attainment barriers will be explored
in greater detail in the subsection entitled ‘Career Attainment Barriers’.

Professional Societies and Civic Groups

When asked to describe the professional societies and civic groups to which they
belong, informants highlighted ACHE, NAHSE, and Medical Group Managers Association
(MGMA).

ACHE is the predominant professional society to which informants belong. There
was a nearly equal representation of ACHE membership between the key informant
subgroups.

All the respondents who identified themselves as members of NAHSE were
executives of color. This is attributable to the fact that NAHSE is a non-profit professional
society with a focus on the advancement specifically of Black healthcare executives. All the
informants that identified themselves as being members of NASHE were also members of
ACHE.

MGMA membership was more common among informants who worked in a for-
profit environment.
**Mentoring**

Responses from informants regarding the role that mentoring played in their career were coded to indicate the presence or absence of mentors at some point during the key informant’s career.

**Additional Finding 4: Informants all assigned a high degree of importance to having mentors that help facilitate career attainment.**

Fewer informants stated that they did not have influential mentors. Most informants interviewed indicated that they benefitted from an influential mentor at some point in their career. There were more executives of color than White executives that did not have mentors. Informants, regardless of whether they actually had a mentor or not, acknowledged the importance of mentoring on the trajectory of a person’s career.

“One of the reasons that I wanted to come here was because the president here has been the most influential leader in my career. I wanted to learn from him the things I need to decide what the next level is.” --- Key Informant F.

“The CEO I used to work for was fantastic. He created exposure for me. He took me to board meetings and medical staff meetings when I was at the age of 24. I had exposure to these things earlier in my career. Most people don’t get that kind of exposure until they are in their thirties or forties.” --- Key Informant X

When sections of text were coded with the code ‘Mentoring’ and plotted against other codes used in the data analysis, there is a noticeable intersection with the coded topics of ‘Unofficial Networks’ and ‘Appointed vs. Hired or Promoted’.

White executives associated mentoring with ‘Unofficial Networks’ and ‘Appointed vs. Hired or Promoted’. Executives of color also associated mentoring with ‘Unofficial Networks’. The responses from executives of color show a lower number of intersections between mentoring and ‘Appointed vs. Hired or Promoted’. HEC responses show a higher number of intersections between mentoring and ‘Career Attainment Barriers’.
In some interviews with healthcare executives of color, it became apparent that some of the informants recognize the linkage between influential mentors and the ability to access unofficial networks that might position them for visibility with the decision makers who make determinations about selection. The intersections of coded text for ‘Unofficial Networks’, ‘Mentoring’, and “Career Attainment Barriers’ reflect this line of reasoning.

**Views on the Selection Process**

A range of responses was provided by informants when they were asked to talk about their views on the selection process for executive level positions. Descriptors ranged from biased to competitive.

*Additional Finding 5: HEC’s typically view the selection process as biased or a combination of biased and competitive. WHE’s typically view the selection process as competitive.*

HEC’s emphasized the fact that selection processes are often influenced by ‘who a person knows’ versus ‘what a person knows’. This notion underpins the development of the coded theme of ‘Unofficial Networks’.

“Being able to get a job without a lot of people knowing you used to be a badge of honor. Now, because of the frequency of regime changes, networking and knowing people is more important.” --- Key Informant A

“It’s not so much about what you know but who you know. It’s difficult for an African American to know people at the senior executive level or to have an executive sponsor.” --- Key Informant H

“I wish I could say the process didn’t have bias, but I can’t. There has not been a consistent process. It’s still, for some positions, about who you know, the good old boy network.” --- Key Informant J

“It’s not what you know, it’s who you know. Blind searches are not as successful anymore.” --- Key Informant K

WHE’s described a selection process that was evolving, improving, and highly competitive. WHE’s tended to display judgmental conflict over the right balance between promoting candidates from within an organization compared to hiring external candidates.
“It’s changing in the sense that we are considering talent from within more than ever before. We are working more on developing internal talent. “It’s important to bring outside talent in for diversity of thoughts and ideas. We are getting better.” --- Key Informant M

“It depends on the organization. We frequently look internally. We will also go to an outside source. The hope is that we are effective in achieving a good balance. In some cases, people are being developed internally; the process may not be that competitive.” --- Key Informant O

“It’s a mixed process. I’m an advocate for promoting from within. I’m an advocate for bringing in new talent. There needs to be the right balance based on the needs of the organization.” --- Key Informant P

The responses from informants reflect views of a selection process that has the potential to be biased, a blend of biased and competitive and competitive (Figure 20). HEC’s described their views on selection processes as either biased or biased/competitive. WHE responses were polarized at the far end of the spectrum toward a purely competitive selection process.

**Figure 20. - Summary of Bias vs. Competition Responses in Selection Process**

![Diagram showing the categories: Biased, Biased/Competitive, Competitive. Biased: More typical HEC perspective. Biased/Competitive: Shared HEC/WHE perspective but more common to HEC’s. Competitive: More typical WHE perspective.]

Views expressed about the selection process by which healthcare executives attain their roles in leadership are very different between the two subgroup classifications. HEC’s describe the selection process as having a high degree of bias. WHE’s see the process as having a higher degree of competition.

**Healthcare Executive of Color Representation**

Additional Finding 6: Informants agree that people of color are underrepresented in executive healthcare leadership roles.
When asked how well they think people of color are represented in healthcare leadership, informants almost unanimously stated that people of color are underrepresented in healthcare.

There was only one healthcare executive who thought that people of color were not underrepresented.

“Pretty well. I don’t even notice color or race when I look at people. There were two executives of color that I know that were recently recognized in Modern Healthcare.” --- Key Informant R.

Informants cited a number of reasons as to why they believe that people of color are underrepresented in the healthcare leadership ranks. Mentoring emerged again as a subtopic from responses provided by executives of color and White executives.

“We lack access to training programs, mentors, we are not around people in the healthcare leadership world. There are not a lot of people to take you under their wing.” --- Key Informant A

“There has been improvement over the last several years in physician leadership, governance and executive physician positions. On the administrative side, opportunity lies with mentoring.” --- Key Informant P

Informants also suggested that one of the causal factors for executives of color being underrepresented in healthcare leadership roles is that there is a shortage of candidates of color to choose from in the applicant pool.

“In my segment, there are not that many people to begin with. It’s a microcosm of healthcare.” --- Key Informant D

“Clearly there could be a focus on recruitment of people of color. The administrative role has not been prominent in the African American community. There are more doctors of color than there are administrators of color.” --- Key Informant G

“We are challenged even more to identify candidates of color who are qualified. Statistically, the talent pool from which to draw candidates of color is smaller.” --- Key Informant M

“When it comes to having a pool of minority candidates, there is an educational and a physical shortage of men of color. More and more women are competing for the roles.” --- Key Informant T

“It’s still underrepresented. As an HR executive, I’ve focused on minority candidates. There are fewer minority candidates available.” --- Key Informant U

“Very poorly represented. There is not a large enough pool from which to draw minority candidates.” --- Key Informant X
Responses suggest that the representation of executives of color may also be impacted by geography. Informants stated that the recruitment of executives of color is more challenging in rural areas. They suggested that executives of color may not be as underrepresented in metropolitan areas that have a greater degree of ethnic diversity within communities.

**Career Attainment Barriers**

Additional Finding 7: HEC’s and WHE’s have different views about career attainment.

Themes from both key informant subgroups were developed around the topic of career attainment barriers. These themes were developed into subcodes to represent types of barriers that impact the attainment of executive healthcare leadership positions (Figure 21). There were instances in which key informant responses overlapped among the subgroups. There were also instances of polarization of key informant responses as was seen with views on the selection process.

**Figure 21. - Career Attainment Barriers Codification**

<table>
<thead>
<tr>
<th>Code</th>
<th>Subcodes</th>
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<tbody>
<tr>
<td>Career Attainment Barriers</td>
<td>• Lack of Mentoring</td>
</tr>
<tr>
<td></td>
<td>• Visibility</td>
</tr>
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<td></td>
<td>• Internal Drive</td>
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<td></td>
<td>• Hiring for Familiarity</td>
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<td></td>
<td>• Tenure</td>
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</tbody>
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**Lack of Mentoring**

Lack of mentoring was almost always described as a barrier by executives of color. The context within which a lack of mentoring was described was as the absence of a resource
that could assist one with gaining access to unofficial networks and inclusion into the inner circles of the decision makers who make decisions about hiring and promotions.

**Visibility**

Visibility describes the key informant’s opportunities to demonstrate his or her abilities in a way that is visible to the senior leaders who may have input into decisions to hire or promote other executives within the organization. Within the context of the responses that they provided, the informants who talked about visibility provided several allusive references to the middle management plateau described during the review of literature.

**Internal Drive**

Internal drive can be thought of as the self-motivation required to overcome barriers to career advancement. In each instance that responses were coded to represent the concept of internal drive, respondents described the need for individuals to proactively form relationships with mentors and decision makers who could have a positive influence the trajectory of the person’s career.

“One thing that would enable success is an individual’s own internal engine to build relationships.” --- Key Informant P

“You have to be willing to do more for the people around you than you do for yourself. There is a lot of turnover in C-suite roles. You have to look at who gets in the door and then how long they stay. Skills override color. You have to learn to deal with crises.” --- Key Informant T

“Folks not actively managing and developing their skills (is a barrier). The jobs are out there but you have to go get them. You have to be open to opportunities wherever they are.” --- Key Informant D

**Pipeline**

Responses coded as pipeline-related barriers refer to the idea that executives of color are underrepresented in healthcare because there is difficulty in identifying them as candidates and getting them into organizations. One key informant also suggested that there might be difficulty in identifying the talents of internal candidates already in the organization
but not yet in an executive level role. Pipeline barriers are also representative of the idea that there is underrepresentation of executives of color because there is an overall shortage of available candidates of color in the selection pool.

**Communication Style**

Communication style refers to an issue that surfaced during inquiries about whether or not informants thought that career attainment barriers were the same or different for executives of color. Communication style was articulated as a possible barrier for healthcare executives of color.

“I do think people of color don’t talk the same way. They speak with more passion is often misunderstood. Our way of doing things is different from the majority. This creates a barrier with the majority bringing you into the fold. Passion is often seen as weakness.” — Key Informant B

“There are stereotypes such as African American women being boisterous, loud and demanding. When I speak up in meetings, some people may perceive it through that lens. I have seen White males go at it in the boardroom and they have been interpreted as being passionate. A Black female in that situation would be viewed as being hard to work with. You can’t be yourself. You have to over-think how you say things to avoid being looked at through certain stereotypes.” — Key Informant L

“If you make the assumption that everyone has the same level of education and the same skills, the greatest barrier would be an inability to adjust your communication style to fit the organization that you are in.” — Key Informant S

**Education**

Educational barriers ranged from not having early exposure to healthcare as a function of being the child of an executive or healthcare provider to the unavailability of educational curricula and residency programs. A number of executives remarked that the quality of MPH (Masters of Public Health) courses has changed over the years, with many of them no longer requiring an administrative residency or administrative fellowship. The discontinuation of leadership development courses due to budget cuts was also described as a barrier.
Educational barriers have the potential to affect candidate selection at a number of critical junctures in a person’s career. Level of educational attainment can be a disqualifier in the early part of a person’s career. A number of executives noted this fact during conversations when they mentioned that a master’s degree is now the minimum requirement for executive level positions.

**Hiring for Familiarity**

Informants stated that there is a tendency for decision makers to hire and promote only those that are familiar to them.

“I do think we tend to see minorities open the door for other minorities. Non-minority people don’t tend to see beyond what is familiar to them.” --- Key Informant C

“Personality types that leadership is compatible with can be a barrier. It’s been a barrier in convincing management that even though my personality is not like yours, I am still capable of getting the job done. When the personality type is different than what the leadership is used to, they have a hard time seeing the person’s abilities. This doesn’t seem to hold true for White counterparts” --- Key Informant E

“Traditionally, people pick people that look and act like them. This limits the scope of experience to call on. It’s not a progressive way to manage your business. The selection process has been historically a confined process. It’s important to develop talent through diversity.” --- Key Informant O

Executives of color provided examples in which they felt that they or someone that they knew had been allowed to assume certain leadership roles because they were “safe” roles. Comments were made about the assumed or observed prevalence of African American women serving as the most senior human resources professional for organizations. One key informant talked about how African Americans, in particular, can be found in high concentrations in some departments and can be absent in other higher level departments.

“We often get stuck in community services or environmental services or other positions that don’t lead to higher level experience or exposure.” --- Key Informant I
Tenure

Tenure can be viewed in a bimodal fashion. Informants expressed that short tenures and extensively long tenures can both be problematic. A short tenure by candidates in executive leadership positions may be viewed unfavorably by senior executives making decisions for new hires or promotions. The candidate may be looked upon as not having spent enough time in one place to be effective.

Informants noted how this is a stark contrast to the traditional view of the hospital CEO who remains at the helm for thirty years. Tenure in the same executive level position for more than three to five years may be perceived as stagnation. Another association that key informants assigned to long tenures is that low turnover in senior level positions limits the number of available senior level positions for which to compete.

A Code-Subcode-Segments model was developed to illustrate which barriers informants described in the most detail (Figure 22). The code ‘career attainment barriers’ was plotted as the central node with the subcodes appearing as branches off of the central node. Branches that are highlighted in red represent the highest density of coded text from key informant responses.
The aggregate code-subcode-segments model illustrates that a lack of mentoring, visibility, and internal drive were the career attainment barriers that informants discussed the most. If a weighting or ranking were to be applied to the subcodes, internal drive would be considered the primary career attainment barrier. Lack of mentoring and visibility would receive equal weighting as the second most prevalent career attainment barriers. The same prioritization could be given to the other subcodes that were not highlighted in red.

A drill-down into the career attainment barrier responses by subgroup reveals some variation between the perspectives of White executives and executives of color. As was seen with the aggregate model, internal drive was a key driver for White executives. White
executives also cited tenure and hiring for familiarity to the same degree as internal drive (Figure 23).

**Figure 23. - WHE Code-Subcode-Segments Model for Career Attainment Barriers**

There is congruence between WHE and HEC responses for internal drive and education (Figure 24).
Although there was some congruence in the responses by White executives and executives of color, there were additional barriers to which executives of color gave more weighting. HEC perspectives about career attainment barriers appear to be focused more toward a lack of mentors and a lack of visibility.

The code-subcode-segments model for White executives differs from the HEC model. Lack of mentoring and visibility were each only discussed once during the respective WHE interviews, as denoted by the singular nodes on the respective branches of the model. Additional contrasts can be seen between WHE and HEC responses when looking at the two models. White executives cited tenure, hiring for familiarity, and pipeline issues more often than executives of color. Executives of color gave more focus to communication.
Informants were asked if they thought that the career attainment barriers that they identified were the same or different for people of color.

HEC responses indicated that aside from the career attainment barriers that all executive healthcare leaders face, there are additional barriers that a person of color faces simply as a function of being a person of color.

Responses from White executives were divided with some of them indicating that they believed HEC’s faced additional barriers and others indicating that they believed that HEC’s faced no additional barriers.

Responses from executives of color were focused heavily on the perception that candidates of color face additional career attainment barriers simply because they are people of color. The White executives that shared this perception also made observations about how additional barriers could be encountered by a person of color because of a person’s belief system or communication style.

Unofficial Networks Revisited

Unofficial networks were frequently acknowledged by both subgroups as potentially being a barrier that could impede career attainment. The effect of unofficial networks has been described as such that selection for a leadership position may have already occurred even though a position is being posted and recruited for.

Interviews with executives of color resulted in additional concepts that represent barriers specifically for healthcare executives of color. These informant-derived concepts include a perception that HEC’s have to work harder than their White counterparts, the
phenomenon of being the only person of color in the room, a suggestion that HEC’s tend to seek out mentors who are most similar to themselves, and HEC’s are rare commodities.

**HEC’s Have to Work Harder**

Some executives of color provided personal accounts of times when they felt like they had to worker harder than their White counterparts simply because they were a person of color.

> “Healthcare executives of color are scrutinized to a higher degree. I remember looking at jobs, being qualified, interviewing, and being passed over or given turnaround projects that no one else wanted. We are often given the hardest jobs. This has been true numerous times across multiple organizations and geographic locations.” --- Key Informant A.

> “We often have to work harder as a person of color because now there are more people to compete against.” --- Key Informant D

> “We have to work harder to show that we should’ve been recruited in the first place.” --- Key Informant F

**Only HEC in the Room**

Executives of color also recounted experiences of when they were the only person of color in a group setting. These group settings were typically business meetings, board presentations, focus groups, or panels.

> “Of the five people at my level in the organization, I am the only person of color; the only African American.” --- Key Informant E

> “I remember a presentation that I did back in the early ’90’s. There were about two hundred people in the room and I was the only person of color in the room.” --- Key Informant E

> “I’m bothered by being the only person of color in a number of meetings.” --- Key Informant I

**HEC’s Should Seek Mentors that are Different**

There was sentiment among informants that executives of color should expand the reach of their mentor/mentee relationships to include people that are ethnically different from them.

> “I would challenge candidates of color to seek out mentors who think differently from them and who are different from themselves.” --- Key Informant P

> “I feel obligated to create a program that is objective, measurable and thoughtful and not necessarily built on relationships. It will involve mentors that might be different from you. Folks don’t actively seek out people that are different from them.” --- Key Informant W
HEC’s are Rare Commodities

White executives expressed difficulty in recruiting executives of color because executives of color are a rare commodity in the workforce.

“A good minority candidate can have their pick of any job they wanted.” --- Key Informant U

“When I was in another organization, we used a recruiter who focused on minority candidates. The recruiter told me that the person that we were looking for with the amount of talent and background that we were seeking would be very hard to find. Minority candidates with that kind of talent typically get snatched up by the Fortune 500 companies and are compensated at levels that could be as high as three times what we were willing to pay in the not-for-profit sector.” --- Key Informant X

The comments from these executives resonate with the perspective held by other informants that there simply are not enough candidates of color in the pipeline that can move into executive leadership roles.
Chapter 5: Discussion

Results from the key informant interviews revealed that White executives and executives of color agree that people of color are underrepresented in executive healthcare leadership roles. Responses support findings from the literature review such as the importance of mentoring, perspectives about barriers that prevent executives of color from getting beyond the middle management plateau, and the importance of cultural competency in promoting access to healthcare to people of color.

Research Question 1: What are the opinions of White healthcare executives and executives of color regarding the race of healthcare executives and how it may affect access to care for people of color?

Key informant responses indicated that both subgroups believe that diversity on the executive healthcare leadership team is important. Responses suggested that more diverse executive leadership teams are more apt to make decisions that increase access to healthcare services for people of color. Informants believe that the level of diversity can have a positive influence on guiding access to healthcare for people of color. Informants also believe that the race of healthcare executives can impact access to healthcare by people of color.

Responses from informants point to the identification of community touch points as one way in which more diverse leadership teams can improve access to healthcare. The most frequently mentioned example of a community touch point was the African American Church. This idea is supported by a previous study that was conducted by Aaron, et al. The study by Aaron, et al. found that African Americans who frequently attended church were
more likely to access healthcare services and engage in healthy behaviors [57]. White healthcare executives and executives of color alike observed that these community touch points might be missed if the leadership team does not have representation from people of color.

**Research Question 2: To what extent do White healthcare executives and executives of color vary in their opinions about solutions for improving access to healthcare for people of color?**

More than any other response, cultural competency was stated by informants as the way in which they would approach solving healthcare disparities for people of color.

Healthcare executives of color and White healthcare executives are in agreement as it relates to cultural competency, healthcare reform, and improving physician reimbursement as ways to combat healthcare disparities for people of color. While these tactics represent agreement of perspective among the subgroups, it is important to note the secondary suggestion for improving disparities, which was Education, was unique to executives of color.

Looking at responses on an aggregate level, the most important tactics to improve access to healthcare for people of color as 1) Cultural Competency, 2) Education, and 3) Healthcare Reform.

In addition to being important for the identification of community touch points, cultural competency was described as providing the ability to see blind spots within policy making that might arise in situations where the perspectives of people of color are not present. Informants described the benefit of culturally competent leadership as a safety mechanism that helps leaders avoid policies that might otherwise limit access to healthcare by people of color.
The focus of this research project deals with the primary tactic of assisting institutions with increasing diversity as a means of increasing cultural competency which will in turn increase access to healthcare services for people of color. The suggestions from informants to use education, healthcare reform, and improving physician reimbursement to address healthcare disparities provide the subject matter for future research projects.

The analysis of the career pathways of the informants involved in this study shines light on how to address the underrepresentation of people of color in executive healthcare leadership roles. The personal accounts of some of the executives of color interviewed illustrate the additional barriers that prevent executives of color from attaining executive leadership roles to the same degree as their White counterparts. Their personal accounts are supported by an updated study that was conducted by ACHE and NAHSE. The 2008 study is an update to the previously cited study that was conducted in 2002. The purpose of the original study and its subsequent updates was to assess the career attainments of members of both professional societies. The assessment was done in an effort to compare career attainments across racial and ethnic strata. Probably the most salient points from the ACHE/NAHSE study were the reports by people of color that discrimination had caused them to not be hired, prevented them from receiving fair compensation, and subjected them to performance evaluation standards that were inappropriate [5]. Almost forty percent of African Americans in the ACHE/NAHSE study stated that they were not promoted because of their race or ethnicity.

The ACHE/NAHSE study supports two assertions that were made by executives of color interviewed in this research project. In the ACHE/NAHSE study, executives of color
reported that they felt that executives of color usually have to be more qualified than others to get ahead in their organization. They also expressed a greater desire for their respective organizations to increase the representation of people of color in senior leadership roles [5].

In 2011, Witt/Kieffer surveyed healthcare leaders across several dimensions. The Witt/Kieffer study found that White executives explain the absence of people of color from executive leadership ranks as being the result of an absence of candidates of color in the applicant pool. In contrast, executives of color said that a lack of commitment by top management to recruit, retain, and promote candidates of color is the primary barrier for career attainment [58].

The findings highlighted in the ACHE/NAHSE study and the Witt/Kieffer studies resonate with comments made by informants during the interviews conducted for this research project. All three studies highlight the need for commitment from the most senior executives within institutions to build more diverse and culturally competent leadership teams. The second most important commonality between the studies is the need for formalized mentoring programs to assist in the development of executives of color.

The implementation plan developed as part of this research addresses the issues associated with getting more candidates of color into the selection processes for executive healthcare leadership roles. The implementation plan provides a pathway for both individuals and institutions to follow from the earliest stages of career development to executive leadership roles. As more and more candidates of color navigate this pathway and overcome the barriers to career attainment, institutions will realize greater levels of diversity and cultural competency.
Limitations of the Research

One of the limitations of this research project is that it was geographically limited to North Carolina and South Carolina. The majority of the executives of color are African American. There was one executive of color who is of Native American descent. The ACHE/NAHSE study and the Witt/Kieffer study were national studies with representation from a larger array of executives of color. Additional ethnic groups such as Asian American, Pacific Islander, and Hispanic were included in those studies but were not represented in this study. One of the disadvantages to geographically limiting the informant pool was that a lack of participation by informants in one state translates into a greater focus on responses from informants from the other state. This was illustrated in the key informant descriptive data. A small number of participants from South Carolina naturally meant that the majority of responses would come from informants in North Carolina. Another disadvantage to the geographical limitation placed on informant selection is that it essentially limited the selection of people of color to primarily African American executives. There were a number of instances during the informant interviews when the author reminded both HECs and WHEs that references to people of color were meant to encompass all people of color and not just African Americans.

The research study was also limited in that the number of informants was small. The intent of this study was to identify an equal number of White executives and executives of color willing to participate in this study. Midway through the interviews of executives of color, it was observed that a number of recurring themes had already been established. These themes reoccurred in the remaining HEC interviews. This was not the case, however, with the interviews of White executives. The saturation point that occurred midway through the
HEC interviews was not observed in the WHE interviews. This suggests that the study may have been benefited from interviewing a larger number of White executives. In many of the scholarly works cited in this study, the sampling frames have included much larger numbers of respondents. Replicating this research study on a larger scale and within a longer timeframe might provide the research community with yet another future research opportunity.

Bias may have been introduced in this study because of the selection of key informants with whom the primary author had an existing relationship before conducting this research. The author made a conscious effort to mitigate selection bias by extending invitations to participate in this study regardless of what the author thought their perspectives on the subject matter of this study might be. The author did not choose people based on how the author thought they might answer the questions. There is a possibility that some of the informants interviewed and the author might share similar or same perspectives on the subject matter involved in this study. In some cases, this might be a result of having worked alongside some of these informants in organizations with specific corporate values such as inclusion, succession planning, and a culture focused on diversity.

Bias may have also been introduced if there were instances in which an informant chose to provide a socially acceptable answer to an interview question as opposed to answering the question based on how he or she truly felt about a particular topic.
Chapter 6: Implementation Plan

Institutions are challenged with harnessing the benefits of diversity while simultaneously building a culture of inclusion that supports members’ personal growth and professional development. This challenge requires organizations to assess whether the time and resources required to promote diversity in leadership are worth the potential payoffs of creativity and the realization of available talent to fill important jobs [59]. To translate this in a way that it is applicable to the healthcare sector, one accepts that diverse leadership teams are inherently more culturally competent than homogenous leadership teams. Furthermore, one gives some consideration to the business case for diversity. Diversity in top management coupled with a growth strategy has been recognized as a competitive advantage that has allowed some firms to outperform others [60].

What can be learned from the literature and from the informant responses in this study is that diversity on the executive leadership team is thought to have a positive influence on access to healthcare by people of color. A more diverse team is likely to be more culturally competent which positions the team to guide policy in a way that is sensitive to the needs of people of color.

This study contributes to the research community by creating a roadmap that can be used to expose students of color to healthcare leadership roles by the time that they are juniors and seniors in high school. This early exposure is the first in a series of transitional phases that leads to a career in executive healthcare leadership. Along each phase of this
continuum, the things learned from the literature and the informant interviews are used to craft an action plan that makes use of the points of entry into healthcare leadership as described by the informants, emphasizes the necessity of mentoring in developing leaders and positioning them for more leadership opportunities.

The continuum to creating a more diverse pool of applicants who may someday become healthcare executives begins with creating an early predisposition to healthcare leadership in high school and extends well into the mid-career years. (Figure 25).

**Figure 25. - Conceptual Model of Tactics to Impact Access through Diversity**

![Conceptual Model of Tactics to Impact Access through Diversity](image)

This roadmap can guide institutions to set forth on the path of improving access to care by building upon cultural competency and diversity. It also shows how players at
various levels of education and experience may influence diversity through employee selection. The roadmap can assist institutions with achieving a greater level of diversity within the candidate pool. Institutions that adopt this model can follow the career development of future leaders all the way from high school to their mid-career years.

By introducing executive healthcare leadership as a career opportunity to youth in the junior and senior years of high school, youth of color might benefit from the same predisposition that is available to a higher percentage of White youth whose parents or other significant figures already dominate executive healthcare leadership roles. There is an opportunity for guidance counselors to present executive healthcare leadership as a viable career alternative to the traditional healthcare roles of doctor or nurse.

The undergraduate school years present an opportunity for advisors in business schools and schools of public health to reinforce the viability of executive healthcare leadership as a career choice. The introduction of undergraduate internships may serve as the first point of entry into healthcare for a number of undergraduate students who might be considering career tracks in public health administration or business. The role of healthcare institutions in this phase of healthcare leader development is to sponsor internships and provide mentors with whom students can form networking relationships.

As new graduates enter the selection pool for careers in healthcare, there are opportunities for boards of directors to affirm their institutions’ commitment to building a diverse leadership team. This can be accomplished by making the recruitment of candidates of color a strategic goal [61]. There is a role here for recruiting firms as well. Recruiting
firms are positioned to assist healthcare institutions with identifying candidates of color at multiple levels of leadership.

The early career development window presents an important juncture in which new healthcare professionals can benefit from the influence of experienced mentors and the use of both official and unofficial networks. The availability of formal mentoring programs and networking opportunities presents another opportunity for institutions to affirm their commitment to increasing diversity in their leadership ranks.

By the time a person reaches the mid-career point, he or she should have already had access to a number of mentors with diverse backgrounds and experiences. Formalized succession plans are a useful tool by which institutions can ensure that corporate identity and values are maintained when turnover happens in key leadership positions. The added advantage for institutions is that this transfer of knowledge will already have been initiated within the framework of formalized mentoring and networking programs. Institutions can also maintain a level of trust with executives of color during selection processes by making the criteria for selection transparent throughout the organization [5]. This disclosure can serve the purpose of enticing executives of color to seek out opportunities within the institution. Transparency in selection criteria can also assist recruiting firms with being more efficient with the identification of talent during recruiting engagements.

*The Role of Educators*

Educators must play a critical role in helping high school students find an early predisposition to healthcare leadership. Guidance counselors may need additional training on the curricula associated with degree programs that serve as entry points into healthcare management and ultimately healthcare leadership. Guidance counselors should assist
students with networking opportunities such as career days and college fairs to connect them with colleges and universities that offer academic tracks into the healthcare space.

The Role Colleges and Universities

Colleges and Universities should draw students, including students of color, into degree programs such as public health, business administration, and public health administration by offering scholarships focused on this academic tracks. Colleges and universities can also draw students’ interests to healthcare leadership by sending college recruiters to high school campuses during career fairs and other informational sessions.

Support to revitalize internships and administrative residency or fellowship programs has been documented from both existing literature and responses from informants interviewed in this study.

The Role of Healthcare Institutions

Healthcare institutions should attract more candidates of color by making diversity a strategic goal. Recruiting, retaining, and promoting candidates of color, requires support from the board of directors and the senior leadership team. Selection criteria for vacancies should be transparent so that mistrust does not develop when a candidate of color is not selected and the gravitation toward thinking that the “good old boy system” is at work can be avoided. Institutions should formalize succession plans and make a concerted effort to include executives of color in those succession plans. Institutions should provide mentors for executives who can assist them with their career development and professional networking [5, 58, 61].
The Role of Recruiting Firms

Recruiting firms can assist institutions with identifying qualified candidates of color. Some recruiting firms are beginning to demonstrate their ability to find and successfully place healthcare executives of color as a competitive advantage over other recruiting firms. Some executives interviewed in the research study expressed that they have purposefully sought out recruiting firms who focus on identifying candidates of color when searching for candidates to fill key positions.

The Role of Government

It is possible that the federal government may direct institutions to become more culturally competent through mandates to provide specific cultural competencies or through the use of financial incentives [62].

Recommendations

Conducting the research for this dissertation has resulted in the attainment of perspectives from a number of healthcare executives who work in a number of different settings, primarily in North Carolina. Their perspectives have highlighted opportunities in which access to care by people of color can be impacted through the evolution of more diverse executive leadership teams and the expansion of cultural competency. The challenges that have been identified have been instrumental in formulating a series of recommendations that can be used as operational tactics to improve diversity in executive healthcare leadership ranks (Figure 26). Strategic objectives that were identified in the conceptual model of tactics to impact access through diversity reappear here with the addition of operational tactics that can be taken.
# Figure 26. - Recommendations to Improve Diversity and Cultural Competency

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Operational Tactics</th>
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| 1. Create opportunities for predisposition to healthcare leadership                 | • Establish career days for junior and senior year high school with an emphasis on healthcare leadership careers  
• Establish future healthcare leader chapters as components of local ACHE chapters for high school students |
| 2. Promote undergraduate internships                                               | • Meet with local school system administrators to form partnerships with undergraduate programs that offer healthcare leadership internships  
• Obtain federal and private funding to establish more internship opportunities  
• Identify healthcare institutions to participate in sponsoring undergraduate internships in healthcare leadership |
| 3. Revive and promote administrative fellowship opportunities                        | • Identify academic programs that offer administrative fellowships  
• Conduct gap analysis to determine if existing programs can meet the demand from students and institutions  
• Obtain funding, if needed, to promote and make more administrative fellowships available |
| 4. Establish organizational commitment to building a diverse leadership team         | • Create a charter and mission statement to form a multidisciplinary collaborative focused on increasing diversity in healthcare leadership  
• Work with ACHE to form the collaborative through presentations to potential member institutions |
| 5. Encourage formal professional mentoring and networks                              | • Recommend that formal professional mentoring programs and networking events become part of corporate goals and center of excellence requirements |
| 6. Include candidates of color in succession planning and promotions                 | • Identify recruiting firms with competency in identifying and placing candidates of color  
• Partner these specialized recruiting firms with healthcare institutions on a consultative basis to guide selection criteria for candidates |
Implementing Sustainable Change

Informants’ frustration and disappointment with historic attempts by healthcare institutions to create diversity programs and promote cultural competency was apparent in several interviews. Informants noted that institutions have failed to successfully implement sustainable change toward higher degrees of diversity. Diversity programs start, then stop and ultimately phase out altogether. The main reason for these false starts is a lack of commitment by the most senior leaders and boards of directors in their respective organizations. This linkage reflects what was learned from the literature review as it relates to the importance of top level management engagement being a requirement for diversity programs to be successful.

Coordinating the roles of educators, colleges and universities, healthcare institutions, professional societies, recruiting firms, and government entities in a way that promotes sustainable improvement in the level of diversity of executive leadership teams will require transformational leadership techniques. Kotter’s eight-step model for transformation provides a framework for understanding how leadership principles can be brought to bear successfully to achieve this change. Kotter’s model serves a dual function in that it illustrates the pitfalls that organizations are subject to when trying to initiate change [63] and it can be viewed as a roadmap to ensure that change initiatives are sustainable [64]. For the purposes of this writing, Kotter’s model is used in this latter form (Figure 27).
### Kotter’s Eight-Step Model for Transformation

<table>
<thead>
<tr>
<th>Kotter’s Eight-Step Process</th>
<th>Description</th>
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<tbody>
<tr>
<td>Establish a Sense of Urgency</td>
<td>Identify crises, potential crises or major opportunities</td>
</tr>
<tr>
<td>Create a Guiding Coalition</td>
<td>Assemble a group empowered to lead change</td>
</tr>
<tr>
<td>Create a Vision</td>
<td>Create the guiding vision and strategies</td>
</tr>
<tr>
<td>Communicate the Vision</td>
<td>Teach new behaviors and communicate the vision</td>
</tr>
<tr>
<td>Empower Others to Act on the Vision</td>
<td>Encourage risk taking and remove barriers</td>
</tr>
<tr>
<td>Create Short-Term Wins</td>
<td>Plan visible performance improvements</td>
</tr>
<tr>
<td>Consolidate Gains and Producing More Change</td>
<td>Use credibility to change systems, structures, &amp; policies</td>
</tr>
<tr>
<td>Institutionalize New Approaches</td>
<td>Illustrate the connection between changes and success</td>
</tr>
</tbody>
</table>

Transitioning from high level strategic objectives to operational tactics that will result in increased diversity of executive healthcare leadership teams will span several years, maybe even decades. In order to ensure that such a movement has chance to succeed, it is necessary to translate a sustainable change model like Kotter’s into manageable segments.

**Establish a Sense of Urgency**

The findings from this study can be used to orchestrate diversity initiatives that go beyond the scope of traditional diversity programs. At the time of this writing, the author is unaware of any existing diversity programs that juxtapose the absence of diversity in executive healthcare leadership and the changing diversity of community populations. This research project has illustrated the degree to which there is a disparity between population diversity and diversity in executive healthcare leadership roles. This research project has also shed light on some of the relational factors that inhibit the proliferation of greater numbers of executives of color. Responses from informants, both White executives and
executives of color, agree that the lack of diversity in executive healthcare leadership is a problem that warrants serious attention.

To create a sense of urgency around the issue of diversity in executive healthcare leadership, the author will share the findings of this research study with a number of thought leaders, policy makers, and stakeholders. At the conclusion of this dissertation process, the author will prepare a briefing note that outlines the findings of the study. This briefing note will be shared with a number of informants who indicated that they would like to know the findings from this research study. The interviews have created an open opportunity for the author to follow up with leaders across a number of organizations to further explain the findings from this study. By conducting a series of post-dissertation presentations to leaders in North Carolina and South Carolina, the author should be able to encourage healthcare institutions to incorporate the findings from this research into strategic goals with a focus on diversity and cultural competency.

To increase the exposure for these findings on a regional level, the author will present a summary of the findings to both the president of ACHE and the president of NAHSE. By sharing the results of this study with ACHE and NAHSE, this research project can provide additional support for the research that both professional societies have already conducted in assessing the evolution of diversity in executive healthcare leadership vis-à-vis the surveys that they have done about the career attainment of people of color in healthcare leadership roles.

With President Obama’s election to a second term, the Patient Protection and Affordable Care Act is likely to remain intact. As healthcare institutions evolve to meet the
requirements of affordable care, they can use the research from this dissertation as a series of guideposts to ensure that they are also delivering culturally competent care. An endorsement from the President or other national figure from the healthcare policy arena would transform the findings of this research project into a catalyst for diversity initiatives focused on increasing cultural competency in the delivery of healthcare services. Such an endorsement would be solicited by way of a letter to the President with a summary of the findings from this research project.

*Create a Guiding Coalition*

Kotter suggests that to create sustainable change, the appropriate coalition must be built. This coalition or team should be comprised of people with strong position power, broad expertise, high credibility, and leadership skills [64]. The ACHE and Witt/Kieffer studies demonstrate that support for diversity initiatives must come from the Board of Directors in order for such initiatives to be successful [5, 58]. Because of its policy statement on diversity, the ACHE is uniquely positioned to lead a multidisciplinary collaborative that is intended to promote diversity and cultural competency in executive healthcare leadership roles.

*“Increasing and Sustaining Racial/Ethnic Diversity In Healthcare Management”-- ACHE Policy Statement*

The ideal coalition should be comprised of members from healthcare institutions willing to participate in a collaborative effort to promote diversity within their leadership ranks. Each institution should designate key personnel to serve as delegates to the larger collaborative. The collaborative should be responsible for uniform vision setting, creating operational tactics to promote diversity, and monitoring the effects of implementing any

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5 *The ACHE’s policy statements can be found online at* [http://www.ache.org/policy/diversity.cfm](http://www.ache.org/policy/diversity.cfm)
changes associated with increasing diversity in executive leadership. Participating healthcare institutions should designate between three to five personnel to attend the larger collaborative meetings. The designees should include representation from the board of directors, senior level leadership, and middle management. One way to approach this is to designate two representatives from each leadership strata. Economies of scale can be realized by incorporating the diversity collaborative meetings into already occurring regional and national ACHE meetings.

Additional collaborative members should include representatives from local high schools, colleges and universities, healthcare recruiting firms, and a representative from the Department of Health and Human Services.

The representatives from the local high schools should be guidance counselors. Guidance counselors can educate students on healthcare career choices including career tracks that would ultimately position students for executive healthcare leadership roles. Guidance counselors can play a huge role in creating the early predisposition to healthcare leadership that I described in the last chapter.

At present, ACHE membership is available to healthcare professionals and undergraduate students. The ACHE should consider developing junior membership chapters at the high school level. Similar to existing chapters for Future Business Leaders of America (FBLA), a high school club for juniors and seniors, a junior ACHE chapter can provide the opportunity for students to learn about healthcare careers prior to going to college.

Representatives from undergraduate and graduate programs will play an important role in helping to get candidates of color into the pipeline. Their contributions will play a
critical role in making program information available to college students who might consider healthcare leadership roles. They will also be responsible for helping to steer students toward internship opportunities and administrative fellowships.

The coalition should also include representatives from healthcare recruiting firms that have developed approaches for identifying candidates of color and successfully preparing them for interviews with healthcare institutions. The author is aware of two such groups that have a focus on candidates of color in executive healthcare leadership. These two recruiting firms would make ideal candidates for participation in the collaborative.

The collaborative would benefit tremendously from having representation from the Department of Health and Human Services. The Health Resources and Services Administration (HRSA) is one of the operating divisions within the Department of Health and Human Resources. The mission of the HRSA is “To improve health and achieve health equity through access to quality service, a skilled workforce and innovative programs” (www.hrsa.gov). The HRSA also promotes diversity initiatives through its grants program, one of which is the Centers of Excellence (COE) designation. The COE designation provides support for programs for underrepresented minorities to obtain degrees from health profession academic programs. In its current state, the COE program supports people who are trying to obtain roles as clinicians. By expanding the scope of COE beyond supporting clinical roles to include the attainment of credentials for executive leadership roles, the HRSA can play an integral role in helping to fill the talent pool with more candidates of color. This would mean more candidates of color that are available to choose for healthcare leadership roles; a way to fill the pipeline.
An appropriate name for this guiding coalition would be the National Healthcare Leadership Diversity Collaborative.

Create a Vision

The mission statement for the collaborative should include language that highlights a focus on increasing diversity in executive healthcare leadership as a means to increasing cultural competency and improving access to healthcare. By having all the participating member organizations adopt this mission statement as part of their respective strategic goals, the promulgation of the collaborative’s vision across multiple organizations will occur.

Communicate the Vision

Communication of the collaborative’s vision can occur through a number of channels. The collaborative vision statement should be included in the followup reports that representatives provide to the participating institutions. Communication of the vision should occur in multiple segments of the hiring process. The collaborative vision and the institutions’ support for it should be noted on job postings and job descriptions. The vision should be communicated during presentations to new hires during new employee orientation. Senior executives, especially President/CEO’s and chairpersons of the boards of directors are encouraged to generate periodic newsletters in which the collaborative’s vision and objectives are clearly emphasized alongside their organizations strategic goals. By presenting this information as part of new employee orientation and reinforcing it from the most senior executives in the organization, institutions can integrate the collaborative vision into their respective corporate mission, vision and values.

Communications should also include marketing materials that are disseminated into the community. Messages about diversity and focus on cultural competency should be
included in tandem with the focus that institutions place on their clinical quality. There are opportunities to include the collaborative vision in print ads, television spots, and radio ads. Institutions should also communicate the collaborative vision on their corporate websites.

ACHE and NAHSE should support the communication process through their respective chapter meetings, conferences, publications, and websites. The HRSA should also include the collaborative vision on its website and in any printed publications that it disseminates to applicants for center of excellence certification.

Empower Others to Act on the Vision

By having member organizations include the collaborative’s mission as a strategic goal, boards of directors, executives, and hiring managers will be influenced to actively pursue greater degrees of diversity during their recruiting processes. Member organizations must make the pursuit of diversity part of the organizational culture. Executives have an opportunity during recurring staff meetings to emphasize the pursuit of diversity as an organizational value. The flow of communication related to the collaborative vision should be used by organizations to create a sense of empowerment at every level of the organization to embrace diversity.

Create Short-Term Wins

Short-term wins can be created by having members of the collaborative agree on a series of attainable goals that can be accomplished in a short amount of time. A number of these wins in close succession can generate needed momentum that will assist organizations with tackling larger problems that can only be addressed over longer periods of time.

These short-term wins should be measurable and they should all focus on the tactics outlined in Figure 25, the conceptual model that was developed to illustrate how access to
care can be impacted through Diversity. The initial goal setting should be focused on the
tasks that are easiest to accomplish and require the least amount of time.

Over the course of the first year of the collaborative, participants should draw
attention in high schools to healthcare management and leadership career options. The high
schools that participate in the collaborative should add a healthcare leadership career
component to career days and similar events. In the event that a high school does not have
an annual career day, one should be created. Representatives of colleges and universities
with healthcare management and leadership curricula should be invited to attend these career
days. Schools should keep data reflecting the numbers of students that attended healthcare
leadership activities at career days as well as the numbers of students that ultimately enroll in
college programs within the healthcare management and leadership track. Colleges and
universities should extend the data tracking associated with these students beyond
enrollment. Colleges and universities should track the number of students who graduate with
degrees that emphasize healthcare management and leadership and the number of students
accepted into internships and administrative fellowships. The HRSA can support this process
by funding scholarship opportunities to obtain leadership credentials in much the same way
that it funds scholarship opportunities to obtain clinical credentials.

Additional tasks that can be completed in the early phases of the collaborative are the
formalization of professional mentoring networks and succession plans by the healthcare
institutions. These should also be established in the first year of the collaborative.

Concurrently, participating recruiting firms should record and report statistics on the
availability and the placement of candidates of color into executive healthcare leadership
roles. Recruiting firms and healthcare institutions will be tasked with monitoring these long-term metrics to ensure that the mission of the collaborative is being met.

**Consolidate Gains and Produce More Change**

The gains made by each of the participating members of the collaborative will be shared on a quarterly basis. This can be done through quarterly meetings or any number of communication formats. The information should flow throughout each of the participating organizations. The collaborative should function as a partnership between high schools, colleges and universities, recruiting firms, healthcare institutions, and the HRSA. The metrics described above should be recorded in a report card so that stakeholders can assess the success of the program and determine if the mission is being met.

**Institutionalize New Approaches**

According to Kotter, there are two primary reasons why transformations do not become anchored as part of corporate culture. The first reason is that organizations may fail to show people how the new way of doing things helps to improve performance. Secondly, organizations may fail to take an adequate amount of time to ensure that the next generation of senior leaders personifies the new way of doing things [63]. To ensure that these two pitfalls are avoided, organizations should communicate their goals for creating a more diverse leadership team and improving cultural competency on a recurring basis. Selection criteria for hiring senior leaders and requirements for promotions should include stipulations that the executives chosen champion the cause for diversity in the leadership ranks. This can also be reinforced through corporate goals that are tied to the leaders’ compensation packages. Recurring communication about goals to improve diversity in executive
healthcare leadership should become a consistent part of corporate messaging, human resource training, and internal and external marketing campaigns.

A Local Call to Action

In addition to developing a national collaborative focused on diversity in executive healthcare leadership, there is an opportunity to create a local call to action. The findings from this research study will also be shared with the director of the North Carolina Health Careers Access Program (NCHCAP). The program promotes awareness of healthcare career opportunities with a focus on increasing the number of people from disadvantaged backgrounds who go on to be trained and employed in healthcare careers (nchcap.unc.edu). NCHCAP offers services that are oriented for both pre-college students and students that are enrolled in college. The pre-college programs resonate with the findings of this research study in terms of focusing on developing an early predisposition to healthcare career opportunities. While these programs appear to be focused on clinical roles, there is an opportunity to expand this focus so that students can be introduced to healthcare leadership roles.

The pre-college programs offered by NCHCAP consist of Health Career Days on the Hill, the Health Careers Information and Enrichment Workshop, the Health Professions Forum, the Health Sciences and Leadership Academy, and the Inspirational Speakers in Science Lecture. The programs designated for college students consist of the Clinical Health Summer Program, the Health Careers Club, the North Carolina Access, Retention and Completion Initiative in the Allied Health Sciences and the Science Enrichment Program. There are opportunities within a number of these programs to partner with the Gillings
School of Public Health and the Department of Health Policy Management in particular, so that a focus on healthcare leadership can be included in these programs (Figure 28).

**Figure 28. - NCHCAP Programs and Partnership Opportunities**

<table>
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<th>NCHCAP Program</th>
<th>Program Module</th>
<th>Description</th>
<th>Partnership Opportunity</th>
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<td>Pre-College</td>
<td>Health Career Days on the Hill</td>
<td>Presentations to high school students about various health careers and college preparation</td>
<td>Include a DrPH student and faculty member from the Gillings School of Public Health as presenters. Provide a tour of the school of public health and its departments.</td>
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<td></td>
<td>Health Professions Forum</td>
<td>Forum for high school students to learn about the various health professions programs offered by colleges and universities in North Carolina</td>
<td>Include speakers from the Department of Health Policy and Management.</td>
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<td></td>
<td>Health Sciences and Leadership Academy</td>
<td>A one-year academic program for rising high school sophomores to gain exposure to college and careers in healthcare</td>
<td>Introduce students to healthcare leadership roles, scholarship opportunities, administrative fellowships, and administrative residencies.</td>
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<tr>
<td></td>
<td>Inspirational Speakers in Science Lecture</td>
<td>Presentations by prominent minority health professionals and scientists about their personal hardships and obstacles while obtaining their educational and career goals</td>
<td>Include DrPH students, school of public health faculty, and minority health executives in the lecture series.</td>
</tr>
<tr>
<td>College</td>
<td>Health Careers Club</td>
<td>An officially recognized student organization that supports students pursuing healthcare careers</td>
<td>Expand membership to include students from non-clinical health related programs.</td>
</tr>
<tr>
<td></td>
<td>Science Enrichment Program</td>
<td>An eight-week honors program for disadvantaged undergraduate students seeking admission into graduate professional programs</td>
<td>Include content to make students aware of healthcare leadership roles and leadership programs.</td>
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</table>
By involving school of public health students and faculty in its existing programs, NCHCAP can expand its focus beyond creating awareness for just clinical or allied health career paths. Through public and private partnerships focused on creating early awareness for students about healthcare leadership as a career option, the NCHCAP, ACHE, and NAHSE can lead the call to action for institutions to assess where they are in terms of diversity in executive healthcare leadership. With such an assessment, institutions can then determine how to go about the business of promoting diversity in their executive leadership teams with the intent of raising the level of cultural competency in their leadership bases. This call to action is a critical component of the plan for change because it can lead to the development of more candidates of color in the pipeline for consideration as hiring opportunities arise.

Summary

The U.S. population is growing increasingly diverse. The ethnic makeup of healthcare leadership teams does not match the diversity of the rapidly changing U.S. population. In addition to being underrepresented in executive healthcare leadership, people of color continue to experience challenges associated with health disparities and decreased access to healthcare services. Increasing diversity in the executive leadership ranks, where perspectives about diversity and cultural competence can shape policy, may play a key role in improving health outcomes for people of color.

The healthcare sector is a rapidly changing environment. Increasing diversity in the population presents new challenges for which traditional approaches to providing care, managing resources, and determining policy are growing increasingly ineffective. Language barriers, for example, have forced healthcare institutions to put into place new systems for
meeting language needs. The basic task of meeting the language needs of a new population of people has forced institutions to pay attention to how culturally competent they are in the delivery of care.

Competition in the healthcare market space is also forcing institutions to pay attention to workforce diversity. Hospitals in more competitive markets and hospitals with more diverse inpatient populations have been found to be more culturally competent [62]. Thirdly, the advent of healthcare reform with an emphasis on patient satisfaction and quality metrics is forcing institutions to pay attention to cultural competence. The patient perspective about cultural competence has already been adopted into quality measures [65]. Quality measures are being used with increasing frequency to determine which institutions are allowed to participate in health plans and receive maximum reimbursement for services rendered. Quality measures are also being used as elimination criteria to exclude some institutions from participation in health plans which could create a debilitating effect on the financial performance of those institutions.

In order for institutions to position themselves competitively in the marketplace, they must look to broaden the level of diversity within their executive leadership teams. Responses from informants interviewed in this study demonstrate that White healthcare executives and executives of color often enter into healthcare leadership in different ways. Whether real or perceived, there are additional barriers that prevent people of color from making the transition from the middle management plateau into senior leadership. In the rare instances that people of color do transition into a higher management tier, they carry with
them a perspective of themselves that they have to work harder so that they might be viewed as just as good as their White counterparts.

White executives have been cited as saying that the reason that people of color are underrepresented in executive healthcare leadership is that there are not enough people of color available in the talent pool [42, 58]. The notion that there is a shortage of candidates of color in the talent pool emerged during the literature review for this research project. It resurfaced during the key informant interviews. The conceptual model of tactics to impact access through diversity outlines the roles for a number of players to facilitate the development of more candidates of color. Existing literature and the informants interviewed in this study have identified that organizational shift toward a more racially diverse leadership profile requires serious commitment from senior leaders and boards of directors.

Executives of color and White executives have perspectives that are at times congruent and at other times are divergent, regarding the race of healthcare executives and how it may affect access to care for people. They also share some of the same patterns of congruent and divergent perspectives on solutions to improving access to healthcare for people of color. It is these areas of divergent perspective that become important when trying to shift organizational culture toward greater diversity.

Just as train passengers in England are often warned as they board the train, it is incumbent upon us all to mind the gap.
### Appendix 1: First Medline Search Results

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## Appendix 2: Second Medline Search Results

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## Appendix 3: EBSCO Business Health Search Results

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Appendix 4: Introductory Email to Potential Key Informants

Dear Mr/Mrs. __________, 

I am a fellow ACHE member and doctoral student at UNC Chapel Hill. I am reaching out to healthcare executives in North Carolina and South Carolina to extend an invitation to participate in my research project for the doctorate of Public Health (DrPH) program requirements.

Participation in the project would mean a 20 minute, strictly confidential, phone interview with me in which I would ask 10 questions. The questions have to do with diversity in executive healthcare leadership.

If you would be interested in participating, let me know and I will try to get something scheduled within the next week or two.

Thanks for your time.

Sincerely,

Reginald A. Silver, MBA
Appendix 5: Telephone Script to Obtain Verbal Consent

Introduction

Hi, my name is Reginald Silver. I am a student in the doctoral program in health leadership in the school of public health at the University of North Carolina Chapel Hill. I would like to interview you as part of my research project. The interview will be conducted via telephone and should last approximately 15 - 20 minutes. The purpose of the interview is to collect thoughts from an array of healthcare executives related to diversity in executive healthcare leadership and any impact, if any, that it may have on access to care for people of color.

Study Objectives

The objectives of this study are to:

1. Determine if views about healthcare access for people of color differ based on a person’s ethnicity and position as a healthcare leader

2. Create awareness of the absence of diversity in healthcare leadership roles by collecting demographic data from a convenience sample of healthcare leaders in a geographically bounded region of the United States

3. Inform researchers, practitioners, and policymakers about the impact that diversity in executive leadership may have on access to healthcare

4. Formulate an action plan to help organizations understand where they are at current state and provide healthcare leaders with tools to recruit, retain, and promote candidates of color

Benefits of Participation in this Study

As a participant in this research study, you will have the opportunity to inform the research community on your views about diversity, how it may potentially affect access to healthcare, and how organizations might face the challenges of dealing with recruiting, retaining, and promoting people of color in key healthcare leadership positions. The information you provide may also help add substance to emergent themes that have already been identified in existing literature.

Possible Risks and Protection of Your Privacy

The risks of participation in this study are negligible. Any possibility that responses you provide to the interview questions could lead others to deduce who you are will be mitigated by coding responses as to having come from one of two subgroups within the interview participant pool. No personally identifying information such as your name, email address, job
title, phone number, etc. will published at any time during or after this study. As an additional safety measure, the data obtained from this research study will reside on a computer that is password protected and accessible only by the researcher(s) involved in this study. In the event that direct quotes from participants are used, such quotes will be attributed to aliases such as “Key Informant A”, “Key Informant B”, “Key Informant C”, and so on.

**Research Participant Rights**

You have the right to ask questions about the study and how your responses to interview questions might be used. This research project has been reviewed by the Institutional Review Board (IRB) at the University of North Carolina at Chapel Hill. Should you wish to contact the IRB about this study, you may call 919-966-3113 or email IRB_subjects@unc.edu.

**Verbal Consent**

Do you consent to participating in this research study?
Appendix 6: Key Informant Interview Questions for Healthcare Executives

1. Tell me what your role is?

2. How did you become a healthcare leader - what was your career path?

3. Describe how you were hired into your current role.

4. To which professional societies or civic groups do you belong?
   a. Describe them.
   b. What are their purposes?
   c. What is your role in each?

5. What role did mentoring play in your career?

6. What is your view of the process of selection for executive level positions?
   a. How competitive is it?

7. How well do you think people of color are represented in healthcare leadership?
   a. Explain.

8. What would you say are the greatest barriers to career progression in healthcare leadership?
   a. Would you say that these barriers are the same or different for candidates of color?

9. To what extent do you think that the level of diversity in executive healthcare leadership has an impact on access to healthcare by people of color?
   a. Do you think that the race of healthcare executives matters when it comes to creating access to healthcare services for people of color?

10. What would your approach be for solving healthcare disparities, particularly for healthcare consumers of color?
References


