CHAPTER 2

Diversity and Cultural Competency in Health Care

Jean Gordon, RN, DBA

LEARNING OUTCOMES

After completing this chapter, the student should be able to:

- Define diversity.
- Define cultural competency.
- Define diversity management.
- Understand why changes in U.S. demographics affect the health care industry.

OVERVIEW

Demographics of the U.S. population have changed dramatically in the past three decades. These changes directly impact the health care industry in regard to the patients we serve and our workforce. By 2050, the term "minority" will take on a new meaning. According to the U.S. Census Bureau, by midcentury the white, non-Hispanic population will comprise less than 50 percent of the nation's population. As such, the health care industry needs to change and adopt new ways to meet the diverse needs of our current and future patients and employees.

The *American Heritage Dictionary of the English Language* (4th ed.) defines diversity as: "(1) the fact or quality of being diverse; difference, and (2) a point in which things differ." Dreachslin (1998) provided us with a more specific definition of diversity. She defined diversity as "the full range of human similarities and differences in group affiliation including gender, race/ethnicity, social class, role within an organization, age, religion, sexual orientation, physical ability, and other group identities" (p. 813). For our discussions, we will focus on the following diversity characteristics: (1) race/ethnicity, (2) age, and (3) gender.

This chapter is presented in three parts. First, we discuss the changing demographics of the nation's population. Second, we examine how these changes are affecting the delivery of health services from both the patient's and employee's perspectives. Because diversity challenges faced by the health care industry are not limited to quality-of-care and access-to-care issues, in part three of our discussions we explore how these changes will affect the health services workforce, and more specifically the current and future leadership within the industry.

9781284083903_CH02_017_048.indd 17 28/07/15 2:30 PM

CHANGING UNITED STATES POPULATION

There is no doubt that the demographic profile of the U.S. population has undergone significant changes within the past 10 years regarding age, gender, and ethnicity (see **Table 2–1**).

Data from the 2010 Census provide insights to our racially and ethnically diverse nation (Humes, Jones, & Ramirez, 2011). According to the 2010 Census, 308.7 million people resided in the United States on April 1, 2010—an increase of 27.3 million people, or 9.7 percent, between 2000 and 2010. The vast majority of the growth in the total population came from increases in those who reported their race(s) as something other than White alone and those who reported their ethnicity as Hispanic or Latino. For the first time in the 2000 Census, individuals were presented with the option to self-identify with more than one race, and this continued with the 2010 Census. Using the five race categories (White, Black/African American, American Indian/Alaska Native, Asian, and Native Hawaiian/Other Pacific Islander) required by federal agencies, there are 57 possible multiple race combinations that could have been selected by individuals in addition to "some other race." In fact, over 7 million or 3 percent of the U.S. population did so in the 2010 Census by identifying with and choosing "some other race" or "two or more races." It is predicted that the number of Americans reporting themselves or their children as multiracial will increase in the future. In addition to the changing ethnic and racial composition of America, another issue is the aging population.

Table 2–1 Population of the United States by Age, Gender, and Race/Ethnicity[a]

	2000		*2010*	
	Number	*Percent*	*Number*	*Percent*
Total population	281,421,906	100.0	308,745,538	100.0
Under age 19	80,473,255	25.7	83,267,556	26.9
Ages 19 to 64	165,956,888	61.9	185,209,998	60.0
Ages 65 and over	34,991,753	12.4	40,267,984	13.0
Males	138,053,563	49.1	151,781,326	49.2
Females	142,368,343	50.9	156,964,212	50.8
White	211,460,626	66.8	196,817,552	63.7
Black	34,658,190	11.0	37,685,848	12.2
Hispanic	35,305,818	11.2	50,477,594	16.3
Asian	10,242,998	3.6	14,465,124	4.7
American Indian	2,475,956	0.0	2,247,098	0.7
Some other race	15,359,073	0.5	1,085,841	0.1
Two or more races	6,826,228	0.2	5,966,481	0.2

[a]Percentages do not add up to 100 percent due to rounding and because Hispanics may be of any race and are therefore counted under more than one category.
Data from U.S. Census Bureau, 2010 Census. DP-1 - United States: Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data: U.S. Census Bureau 2000 Census Data as shown in the 2009 Population Estimates table; U.S. Census Bureau: National Population Estimates; Decennial Census.

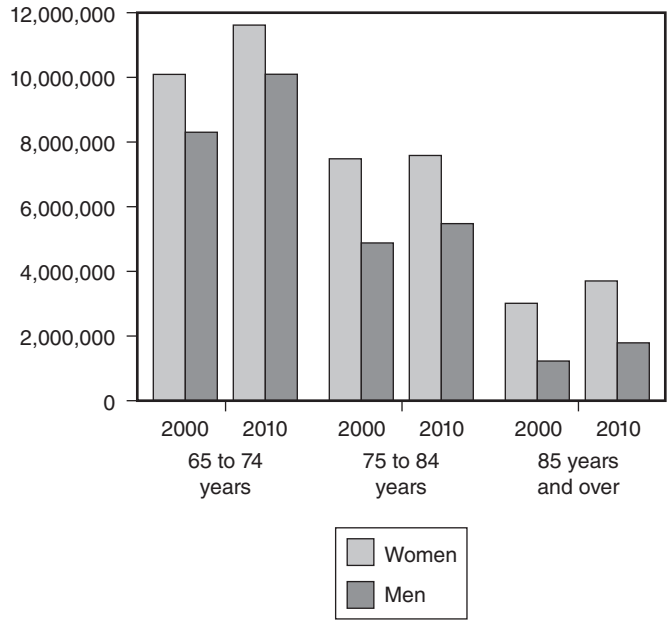


Figure 2–1 Population 65 Years and Over by Age and Sex, 2000 and 2010 (numbers in thousands)

Data from U.S. Census Bureau, 2010 Census. DP-1 - United States: Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data: U.S. Census Bureau 2000 Census Data as shown in the 2009 Population Estimates table.

According to the 2010 Census, 40 million people (13 percent of the U.S. population) are 65 years of age or older. This is 12.3 million more people than in 2000 (see **Figure 2–1**).

During the past decade, the population aged 65 and over grew at a faster rate (15.1 percent) than the population under age 45. This trend was expected as the Baby Boomers (those born between 1946 and 1964) began reaching age 65 in 2011 (see **Figure 2–2**).

In addition to the increasingly older population, there is a declining number of young people in America. From 1940 to 2010, the percentage of the American population under the age of 18 fell from 31 percent to 24 percent (U.S. Census Bureau, 2012). This decline in America's younger population will have a direct effect on the industry's ability to recruit health care professionals to provide sufficient services in the future. Young people of all ethnicities must be attracted to the health care industry as a career choice in order to meet the health care needs of the country's growing population.

Males and females are almost evenly divided for the total population, representing 49.2 percent and 50.8 percent, respectively; however, in the population under 25 years, males dominate females, with 105 males for every 100 females. Among older adults, the male–female ratio reverses, with women outnumbering men. However, there was an interesting change in the male–female ratios for the population aged 60 and older between 2000 and 2010 (Howden & Meyer, 2011). A greater increase in the male population relative to the female population for these age groups was noted. Males aged 60 to

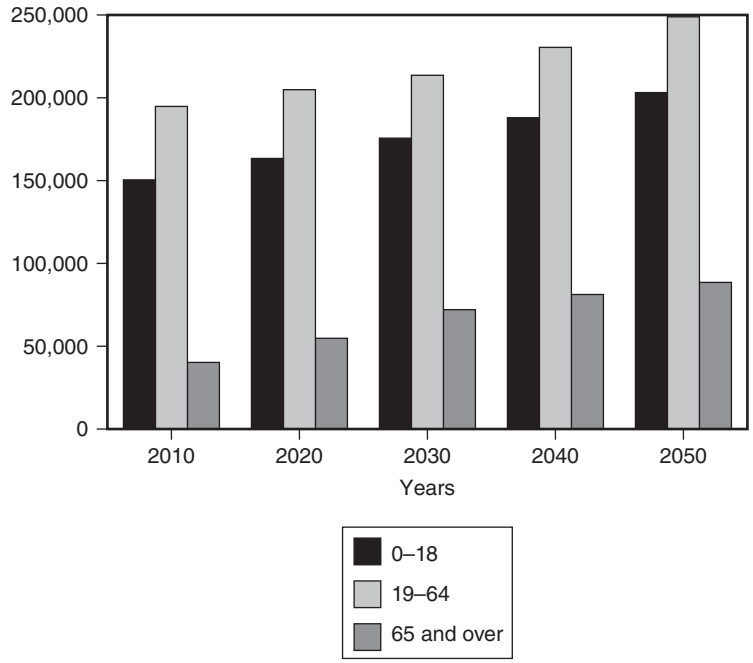


Figure 2–2 Projected Population of the United States by Age, 2000–2050 (Numbers in thousands)

Data from Population Division, U.S. Census Bureau.

74 increased by 35.2 percent, while their female counterparts increased by 29.2 percent. A narrowing of the mortality gap between men and women at older ages in part accounts for this difference.

Race/Ethnicity

The U.S. population has continued to diversify during the past 10 years, as minority populations continue to increase at a faster rate than the White population. Although the White population still represents the largest group (63.7 percent) of the U.S. population, this is down from 75.1 percent in 2000 (see Table 2–1).

In 2010, the Hispanic population represented the largest minority in the United States, 16.3 percent of the population. This is up from 4.5 percent in 1970, the first census in which Hispanic origin was identified. The remaining population is composed of 12 percent Black, 5 percent Asian and Pacific Islanders, 1 percent American Indians and Alaska Natives, and 3 percent those who identified themselves as belonging to another or more than one race (see Table 2–1).

The Asian population in the United States is increasing rapidly as a percentage of the total population. From 2000 to 2010, the population of those

people who identified themselves as being Asian (either alone or in combination with another race) grew 43.3 percent, while the total population grew only 9.7 percent (see Table 2–1)

Aging Population

The world's population is aging. According to the United Nations (2013), slow population growth brought about by reductions in fertility leads to population aging; that is, it produces populations where the proportion of older persons increases while that of younger persons decreases. Globally, the number of persons aged 60 and over is expected to more than triple by 2100, which will represent 34 percent of the world's population, or more than 3 billion individuals. Of this group, the number of persons aged 80 and over is projected to increase almost sevenfold by 2100, representing just under one-third of the world's population aged 60 and over.

The United States is experiencing the same as the world's aging population. As reported by Howden and Meyer (2011), the 2010 Census reflects that the number of people under age 18 was 74.2 million (24.0 percent of the total population). The younger working-age population, ages 18 to 44, represented 112.8 million persons (36.5 percent). The older working-age population, ages 45 to 64, made up 81.5 million persons (26.4 percent). Finally, the 65 and over population was 40.3 million persons (13.0 percent). Between 2000 and 2010, the population under the age of 18 grew at a rate of 2.6 percent. The growth rate was even slower for those aged 18 to 44 (0.6 percent). On the opposite side, the country is experiencing substantially faster growth rates for older ages. For example, the population aged 45 to 64 grew at a rate of 31.5 percent. The large growth in this age group is primarily attributable to the aging of the Baby Boom population. As noted previously, the growth rate (15.1 percent) of the 65 and over population was faster than the population under age 45.

One of the most striking characteristics of the older population is the change in the ratio of men to women as people age. As Howden and Meyer (2011, p. 3) point out, this is a result of differences in mortality for men and women, where women tend to live longer than men. As such, there are more females then males at older ages. However, over the past decade an increase in the male population relative to the female population has been noted. For example, in 2010, there were 96.7 males per 100 females, representing an increase from 2000, when the ratio was 96.3 males per 100 females (Howden & Meyer, 2011). This lowering of male mortality may be attributible to technological advances, more preventive screening, and healthier lifestyles.

While the elderly population is not as racially and ethnically diverse as the younger generations, it is projected to increase in its racial and ethnical makeup over the next four decades. As in the past, the highest proportion of the U.S. population aged 60 and over is White (78.8 percent). However, within the racial composition of the older population, White is projected to decrease by 10 percent by 2050, and all other race groups will increase in their own populations. This change is already being seen. In 2000, the aged White population was 82.5 percent, a 7 percent decrease compared with 2010. The remaining makeup of this population group is 8.8 percent Black, 7.3 percent

9781284083903_CH02_017_048.indd 21 28/07/15 2:30 PM

Hispanic, and 3.6 percent Asian, with other races forming the remainder. As noted, this population group's racial composition will continue to change over the next 40 years.

Gender

As previously noted, according to the U.S. Census Bureau, in 2010, 50.8 percent of the U.S. population was female, and 49.2 percent was male—almost identical to the 2000 Census. That translates to 96 men for every 100 women. However, the ratio of men to women varies significantly by age group. There were about 105 males for every 100 females under 25 in 2010, reflecting the fact that more boys than girls are born every year and that boys continue to outnumber girls through early childhood and young adulthood. However, the male–female ratio declines as people age. For men and women aged 25 to 54, the number of men for each 100 women in 2010 was 99. Among older adults, the male–female ratio continued to fall as women increasingly outnumbered men. For people 55 to 64, the male–female ratio was 93 to 100, but for those 85 and older, there were only 48 men for every 100 women. These male–female ratios reflect a new trend that has been occurring since 1980. From 1900 to 1940, there were more males. Beginning in 1950, there were increasingly more females due to reduced female mortality rates. This trend reversed between 1980 and 1990 as male death rates declined faster than female rates and as more men immigrated to the United States than women (United States Department of Commerce, 2003).

When we look at education, it appears that females are outpacing men. Among the population aged 25 and older, 88 percent of both men and women were high school graduates. But of this group, 39 percent of men had graduated from college, as compared with 61 percent of women. However, even with college degrees, only a high minority (44 percent) of women are employed in management or professional positions.

IMPLICATIONS FOR THE HEALTH CARE INDUSTRY

The changing demographics of America's population affect the health care industry twofold. First, health care professionals and organizations need to have cultural and linguistic competence to provide effective and efficient health services to diverse patient populations. However, before we continue our discussion, we need to define what is meant by cultural and linguistic competence. Over the years, cultural competence has been defined in many ways, such as "ongoing commitment or institutionalism of appropriate practice and policies for diverse populations" (Brach & Fraser, 2000; Weech-Maldonado et al., 2002; see Hofstede's Cultural Dimensions, **Exhibit 2–1**). Linguistic competence has been defined as "the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities" (Goode & Jones, 2004). For our discussions we adopted the definition used by the Office of Minority Health (OMH)

Exhibit 2–1 Hofstede's Cultural Dimensions

One of the most extensive cross-cultural surveys ever conducted is Hofstede's (1983) study of the influence of national culture on organizational and managerial behaviors. National culture is deemed to be central to organizational studies, because national cultures incorporate political, sociological, and psychological components.

Hofstede's research was conducted over an 11-year period, with more than 116,000 respondents in more than 40 countries. The researcher collected data about "values" from the employees of a multinational corporation located in more than 50 countries. On the basis of his findings, Hofstede proposed that there are four dimensions of national culture, within which countries could be positioned, that are independent of one another. Hofstede's (1983, pp. 78–85) four dimensions of national culture were labeled and described as:

- *Individualism–Collectivism:* Individualism–collectivism measures culture along a self-interest versus group-interest scale. Individualism stands for a preference for a loosely knit social framework in society wherein individuals are supposed to take care of themselves and their immediate families only. Its opposite, collectivism, stands for a preference for a tightly knit social framework in which individuals can expect their relatives, clan, or other in-group to look after them in exchange for unquestioning loyalty. Hofstede (1983) suggested that self-interested cultures (e.g., individualism) are positively related to the wealth of a nation.
- *Power Distance:* Power Distance is the measure of how a society deals with physical and intellectual inequalities, and how the culture applies power and wealth relative to its inequalities. People in large Power Distance societies accept hierarchical order in which everybody has a place, which needs no further justification. People in small Power Distance societies strive for power equalization and demand justification for power inequalities. Hofstede (1983) indicated that group-interest cultures (e.g., Collectivism) have large Power Distance.
- *Uncertainty Avoidance:* Uncertainty Avoidance reflects the degree to which members of a society feel uncomfortable with uncertainty and ambiguity. The scale runs from tolerance of different behaviors (i.e., a society in which there is a natural tendency to feel secure) to one in which the society creates institutions to create security and minimize risk. Strong Uncertainty Avoidance societies maintain rigid codes of belief and behavior and are intolerant toward deviant personalities and ideas.
- *Weak Uncertainty:* Avoidance societies maintain a more relaxed atmosphere in which practice counts more than principles and deviance is more easily tolerated.
- *Masculinity Versus Femininity:* Masculinity versus femininity measures the division of roles between the genders. The masculine side of the scale is a society in which the gender differences are maximized (e.g., need for achievement, heroism, assertiveness, and material success). Feminine societies are ones in which there are preferences for relationships, modesty, caring for the weak, and the quality of life.

Hofstede proposed that the most important dimensions for organizational leadership are Individualism/Collectivism and Power Distance, and the most important for decision-making are Power Distance and Uncertainty Avoidance. Uncertainty Avoidance plays an integral part in a country's culture regarding change. For example, Nahavandi and Malekzadeh (1999, pp. 495–496) point out that countries such as Greece, Portugal, and Japan have national cultures that do not easily tolerate uncertainty and ambiguity. Therefore, the resultant behavior emphasizes the issue avoidance or the importance of planned and well-managed activities. Other countries, such as Sweden, Canada, and the United States, are able to tolerate change because of the potential for new opportunities that may come with change.

The question frequently asked is whether Hofstede's (1983) cultural dimensions are still applicable today. Patel (2003) found that the characteristics of Chinese, Indian, and Australian cultures corroborated Hofstede's study results. Patel's study of the relationship between business goals and culture, measured by correlating the relative importance attached to the

(*continues*)

Exhibit 2–1 (Continued)

various business goals with the national culture dimension scores from Hofstede's study, found that although the four cultural dimension scores were nearly 20 years old, they were validated in this large, cross-national survey. In a study that measured 1,800 managers and professionals in 15 countries, statistically significant correlations with the Hofstede indices validated the applicability of the first study's cultural dimension findings (Hofstede et al., 2002). The findings from these studies suggest that Hofstede's cultural dimensions continue to be robust and are still applicable measure components of national culture differences.

NOTE: Hofstede (1991) subsequently included an additional dimension based on Chinese values referred to "Confucian dynamism." Hofstede renamed this dimension as a long-term versus short-term orientation in life.

of the U.S. Department of Health and Human Services, which defines "cultural and linguistic competence as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and that enables effective work in cross-cultural situations." (United States Department of Health and Human Services, 2013).

Second, because of the changing demographics of the nation's population, the health care industry needs to ensure that the health care workforce mirrors the patient population it serves, both clinically and managerially. As noted by Weech-Maldonado et al. (2002), health care organizations must develop policies and practices aimed at recruiting, retaining, and managing a diverse workforce in order to provide both culturally appropriate care and improved access to care for racial/ethnic minorities.

DIVERSITY ISSUES WITHIN THE CLINICAL SETTING

Consider the following:

> *Scenario One:* An insulin-dependent, indigent black non-Hispanic male was treated at a predominantly Hispanic border clinic. Later, he was brought back to the clinic in a diabetic coma. When he awoke, the nurse who had counseled him asked whether he had been following her instructions. "Exactly!" he replied. When the nurse asked him to show her, the monolingual Spanish-speaking nurse was startled when the patient proceeded to inject an orange and eat it.
>
> *Scenario Two:* As Maria (an elderly, monolingual Hispanic female) was being prepared for surgery, which was not why she came to the hospital, her designated interpreter (a young female relative) was told by an English-speaking nurse to tell Maria that the surgeon was the best in his field and she'd get through this fine. The young interpreter translated, "the nurse says the doctor does best when he's in the field, and when it's over you'll have to pay a fine!"

These may seem rather humorous misunderstandings, but real-life experiences such as these happen every day in the United States (Howard, Andrade,

& Byrd, 2001). For example, a survey by the Commonwealth Fund (2002) found that black non-Hispanics, Asian Americans, and Hispanics are more likely than white non-Hispanics to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving health care, to experience access barriers to care, such as lack of insurance or not having a regular physician, and to feel they would receive better care if they were of a different race or ethnicity. In addition, the survey found that Hispanics were more than twice as likely as white non-Hispanics (33 percent versus 16 percent) to cite one or more communication problems, such as not understanding the physician, not being listened to by the physician, or not asking questions they needed to ask. Twenty-seven percent of Asian Americans and 23 percent of black non-Hispanics experience similar communication difficulties.

Cultural differences between providers and patients affect the provider–patient relationship. For example, Fadiman (1998) related a true and poignant story of cultural misunderstanding within the health care profession. Fadiman described the story of a young female epileptic Hmong immigrant whose parents believed that their daughter's condition was caused by spirits called "dabs," which had caught her and made her fall down, hence the name of Fadiman's book *The Spirit Catches You and You Fall Down*. The patient's parents struggled to understand the prescribed medical care that only recognized the scientific necessities, but ignored their personal belief about the spirituality of one's soul in relationship to the universe. From a unique perspective, Fadiman examined the roles of the caregivers (physicians, nurses, and social workers) in the treatment of ill children. She studied the way the medical care system responded to its own perceptions that the family was refusing to comply with medical orders without understanding the meaning of those orders in the context of the Hmong culture, language, and beliefs.

Because of our increasingly diverse population, health care professionals need to be concerned about their cultural competency, which is more than just cultural awareness or sensitivity. Although formal cultural training has been found to improve the cultural competence of health care practitioners, Kundhal (2003) reported that only 8 percent of U.S. medical schools and no Canadian medical schools had formal courses on cultural issues. However, changes are occurring within the industry (see **Exhibit 2–2**) to assist health care practitioners in the developing of their cultural competences as they encounter more diverse patients. For example, in 2000 the Liaison Committee on Medical Education (LCME), the accrediting body of medical schools, introduced the following accreditation standard for cultural competence:

> The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in healthcare delivery, while considering first the health of the patient.

This standard has given added impetus and emphasis to medical schools to introduce education in cultural competence into the undergraduate medical curriculum (Association of American Medical Colleges, 2005, p. 1). In addition,

Exhibit 2–2 Unequal Treatment

A study in 2002 by the Institute of Medicine, entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* found that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicated that U.S. racial and ethnic minorities receive even fewer routine medical procedures and experience a lower quality of health services than the majority of the population. For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery, and are less likely to receive kidney dialysis or transplants. By contrast, they are more likely to receive certain less desirable procedures, such as lower-limb amputations for diabetes.

The study's recommendations for reducing racial and ethnic disparities in health care included increasing awareness about disparities among the general public, health care providers, insurance companies, and policy makers.

———

Modified from unequal treatment: Confronting racial and ethnic disparities in health care (p. 3), by B. D. Smedley, A. Y. Stitch, and A. R. Nelson (Eds.), 2002, Washington, DC: National Academy of Sciences, Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care.

The Joint Commission has implemented patient-centered communication accreditation standards, which require hospitals to meet certain mandates related to qualifications for language interpreters and translators, identifying and addressing patient communication needs, collecting patient race and ethnicity data, patient access to a support individual, and nondiscrimination in care (The Joint Commission, 2014).

Over the past decade, the Commonwealth Fund has been a leader in the effort "to eliminate the cultural and linguistic barriers between health care providers and patients, which can interfere with the effective delivery of health services" (Beach, Saha, & Cooper, 2006, p. vi). The Commonwealth Fund (2003), in addition to funding initiatives regarding quality of care for underserved populations, has also initiated an educational program that assists health care practitioners in understanding the importance of communication between culturally diverse patients and their physicians, the tensions between modern medicine and cultural beliefs, and the ongoing problems of racial and ethnic discrimination. The goals of this program are for clinicians to:

1. Understand that patients and health care professionals often have different perspectives, values, and beliefs about health and illness that can lead to conflict, especially when communication is limited by language and cultural barriers.
2. Become familiar with the types of issues and challenges that are particularly important in caring for patients of different cultural backgrounds.
3. Think about each patient as an individual, with many different social, cultural, and personal influences, rather than using general stereotypes about cultural groups.

4. Understand how discrimination and mistrust affect the interaction of patients with physicians and the health care system.
5. Develop a greater sense of curiosity, empathy, and respect toward patients who are culturally different, and thus be encouraged to develop better communication and negotiation skills through ongoing instruction.

Reproduced from World's Apart, Facilitator's Guide by Alexander Green, MD, Joseph Betancourt, MD, MPH, and J. Emilio Carrillo, MD, MPH, The Commonwealth Fund, p. 4.

In addition to the Commonwealth Fund, the W. K. Kellogg Foundation has led efforts to lessen the recognized disparity of racial and ethnic minority groups' representation among the nation's health professionals. It was the Kellogg Foundation that requested the Institute of Medicine's (2004) study entitled *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. The Institute of Medicine found that racial and ethnic diversity is important in the health professions because:

1. Racial and minority health care professionals are significantly more likely than their peers to serve minority and medically underserved communities, thereby helping to improve problems of limited minority access to care.
2. Minority patients who have a choice are more likely to select health care professionals of their own racial or ethnic background. Moreover, racial and ethnic minority patients are generally more satisfied with the care that they receive from minority professionals, and minority patients' ratings of the quality of their health care are generally higher in racially concordant than in racially discordant settings.
3. Diversity in health care training settings may assist in efforts to improve the cross-cultural training and competencies of all trainees.

In addition to the Commonwealth Fund and the W. K. Kellogg Foundation, other organizations are active in bridging cultural differences in an attempt to lessen health disparities. For example, in 2000 the OMH developed a list of standards for Culturally and Linguistically Appropriate Services (CLAS), which health care organizations and practitioners should use to ensure equal access to quality health care by diverse populations. In 2013, these standards were expanded to reflect the growth in the field of cultural and linguistic competency. There are now 15 standards under four categories: (1) Principal Standard, (2) Governance, Leadership, and Workforce, (3) Communication and Language Assistance, and (4) Engagement, Continuous Improvement, and Accountability.

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Reproduced from the National CLAS Standards, The office of Minority Health, U.S. Department of Health and Human Services.

Another diversity area that has shown progress since 2007 is the use of the Healthcare Equality Index (HEI) of the Human Rights Campaign (HRC) Foundation by hospitals and other organizations. This survey is a resource for health care organizations seeking to provide equitable, inclusive care to lesbian, gay, bisexual, and transgender (LGBT) Americans—and for LGBT Americans seeking health care organizations with a demonstrated commitment to their care (HRC, 2014). In 2013, facilities in all 50 states and most

U.S. veterans hospitals participated in using the HEI, with 93 percent and 87 percent reporting that sexual orientation and gender identity were included in their patient nondiscrimination policies, respectively. These nondiscrimination policies are required for Joint Commission accreditation. In addition, both The Joint Commission and the Centers for Medicare and Medicaid Services require that facilities allow visitation without regard to sexual orientation or gender identity. Furthermore, 96 percent and 85 percent of participants reported that sexual orientation and gender identity, respectively, were also included in their employment nondiscrimination policies. The HEI has two sections: (1) the core four leader criteria and (2) the additional best practices checklist. The Core Four Leader Criteria are reflected in **Table 2–2**. The Additional Best Practices Checklist is designed to familiarize HEI participants with other expert recommendations for LGBT patient-centered care, to help identify and remedy gaps.

AGING POPULATION

In addition to the changing ethnic and racial composition of America, another area of concern is the growing elderly population. Technology has given us the ability to enhance longevity; the challenge now is whether or not the health care profession can learn how to best serve this growing population of patients.

As our citizens grow older, more services are required for the treatment and management of both acute and chronic health conditions. The profession must devise strategies for caring for the elderly patient population. America's older citizens are often living on fixed incomes and have small or nonexistent

Table 2–2 Health Care Equality Index's Core Four Leader Criteria

Criteria	
Patient Nondiscrimination	a. Patient nondiscrimination policy (or patients' bill of rights) includes the terms "sexual orientation" and "gender identity" b. LGBT-inclusive patient nondiscrimination policy is communicated to patients in at least two documented ways
Equal Visitation	a. Visitation policy explicitly grants equal visitation to LGBT patients and their visitors b. Equal visitation policy is communicated to patients in at least two documented ways
Employment Nondiscrimination	Employment nondiscrimination policy (or equal employment opportunity policy) includes the terms "sexual orientation" and "gender identity"
Training in LGBT Patient-Centered Care	Staff receive training in LGBT patient-centered care

Copyright © 2014 by the Human Rights Campaign Foundation. Reproduced with permission. No further reproduction or distribution is permitted without written permission from the Human Rights Campaign Foundation.

support groups. Although this may be considered an American infrastructure dilemma, the reality is that medical professionals must be able to understand and empathize with poor, sick, elderly people of all races, sexes, and creeds.

The term "ageism" was coined in 1968 by Robert N. Butler, M.D., a pioneer in geriatric medicine and a founding director of the National Institute on Aging (NIA). Butler was among the first to identify the phenomenon of age prejudice, initially describing it as "a systematic stereotyping of and discrimination against people because they are old."

Ageism can be defined as "any attitude, action, or institutional structure, which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age" (Traxler, 1980, p. 4). Health care professionals often make assumptions about their older patients on the basis of age rather than functional status (Bowling, 2007). This may be due to the limited training physicians receive in the care and management of geriatric patients. For example, Warshaw and colleagues (2002, 2006) related that medical residents have only limited training in geriatric medicine. Findings from Warshaw et al.'s 2006 study were compared with those from a similar 2002 survey to determine whether any changes had occurred. Of the participating three-year residency training programs, only 9 percent required six weeks or more of training. As in 2002, the residency programs continue to depend on nursing home facilities, geriatric preceptors in nongeriatric clinical ambulatory settings, and outpatient geriatric assessment centers for the medical residents' geriatrics training. A report from the Alliance for Aging Research (2003) related that there continue to be shortcomings in medical training, prevention, screening, and treatment patterns that disadvantage older patients. The report outlined five domains of ageism in health care:

1. Health care professionals do not receive enough training in geriatrics to properly care for many older patients.
2. Older patients are less likely than younger people to receive preventive care.
3. Older patients are less likely to be tested or screened for diseases and other health problems.
4. Proven medical interventions for older patients are often ignored, leading to inappropriate or incomplete treatment.
5. Older people are consistently excluded from clinical trials, even though they are the largest users of approved drugs.

On a positive note, Perry (2012) relates that progress against systematic ageism in health care has begun, in part, due to the passing of the 2010 Affordable Care Act (ACA). He notes that the law's various provisions, such as Medicare's increased focus on chronic disease prevention, new models of care for reducing re-hospitalizations, and improved care coordination, as well as annual screening for cognitive impairment, will assist with changing attitudes toward elderly patients.

Before moving to our next discussion regarding diversity management, we pause to provide a brief overview of the efforts being made regarding the measuring and reporting of cultural competency. Measurement and reporting are needed to ensure that culturally competent care can be translated into:

9781284083903_CH02_017_048.indd 30 28/07/15 2:30 PM

(1) improved health outcomes and more patient-centered care, and (2) actionable initiatives for providers that result in meaningful improvement. Through the support of the Robert Wood Johnson Foundation (RWJF), in 2009, the National Quality Forum (NQF) endorsed a comprehensive national framework based on a set of seven interrelated domains (and multiple subdomains) for evaluating cultural competency across all health care settings, as well as a set of 45 recommended practices based on the framework. This was followed by RAND's development of a cultural competency implementation measurement tool. This tool is an organizational survey designed to assist health care organizations in identifying the degree to which they are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices. In 2012, NQF endorsed 12 quality measures that address health literacy, language access, cultural competency, leadership, and workforce development (RWJF, 2014). These quality measures are the first endorsed by NQF that specifically address health care disparities and cultural competency.

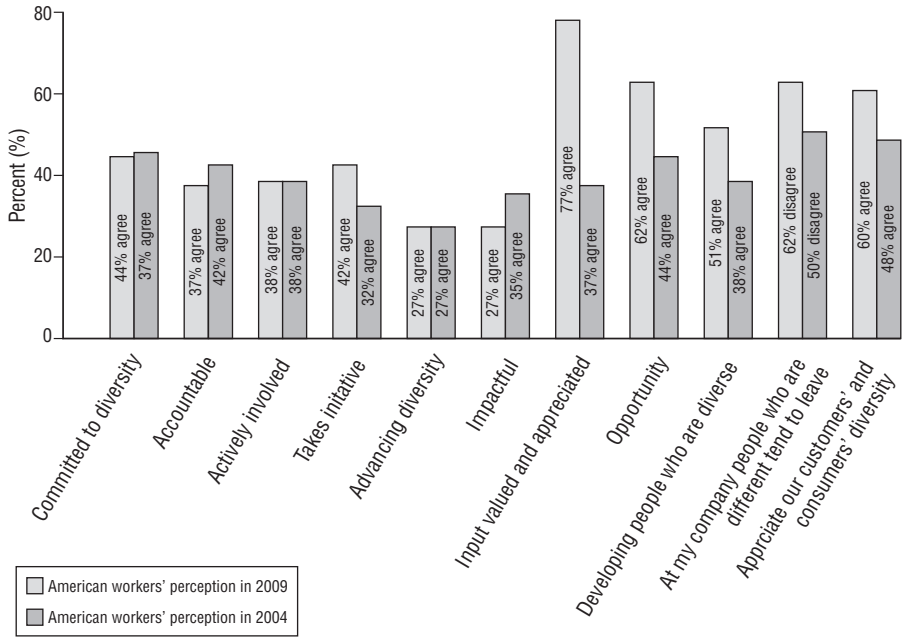
DIVERSITY MANAGEMENT

Diversity management is a challenge to all organizations. Diversity management is "a strategically driven process whose emphasis is on building skills and creating policies that will address the changing demographics of the workforce and patient population" (Svehla, 1994; Weech-Maldonado et al., 2002). In 2004, the National Urban League published its first study on employees' perceptions regarding the effectiveness of their companies' diversity programs. The results of the organization's 2009 follow-up survey found that progress has been made over the past five years in certain areas. However, leadership commitment to diversity and companies clearly communicating their platform on how they value diversity are still lagging (see **Table 2–3**).

As reflected in Table 2–3, organizations have improved in communicating effectively regarding their diversity platforms but need to focus on their (1) commitment to, (2) accountability for, (3) action on, and (4) measurement of these initiatives. The good news is the notable increases reflecting the intrinsic acceptance of diversity and inclusion by the American worker. As reported by the National Urban League (2009), the playing field appears more level, diverse talent is being developed and retained, and customer/consumer diversity is being recognized.

While some gains have been made in regard to increasing diversity in the field of health care management, recent studies continue to suggest that there is still ample room for improvement. The Institute for Diversity in Health Management, an affiliate of the American Hospital Association, was formed in 1994 to address the problem that was disclosed in a 1992 study that minorities held less than 1 percent of top management positions within the industry. In addition, the study revealed that African American health care executives made less money, held lower positions, and had less job satisfaction than their white counterparts. A 1997 follow-up study, expanded to include Latinos and Asians, found that although the gap had narrowed in some areas, not

Table 2–3 American Workers' Perception



Data from National Urban League. Diversity Practices That Work: The American Worker Speaks II, 2009 Highlights.

much had changed. As examples, a study by Motwani, Hodge, and Crampton (1995) found that only 27.7 percent of health care workers in six Midwest hospitals felt that their institutions had a program to improve employee skills in dealing with people of different cultures, and only 38.9 percent felt that management realized that cultural factors were sometimes the cause of conflicts among employees. Weech-Maldonado, et al. (2002) found that hospitals in Pennsylvania had been relatively inactive with employing diversity management practices, and equal employment requirements were the main driver of diversity management policy. Five years later, Weech-Maldonado and colleagues (Weech-Maldonado, Elliott, Schiller, Hall, Dreachslin, & Hays, 2007; Weech-Maldonado, Elliott, Schiller, Hall, & Hays, 2007) continued to find low levels of diversity management activity within California hospitals. Since that time, the Institute for Diversity in Health Management, in collaboration with other organizations, designed several initiatives to expand health care leadership opportunities for ethnically, culturally, and racially diverse individuals, thus increasing the number of these individuals entering and advancing in the field.

HEALTH CARE LEADERSHIP

The American College of Healthcare Executives (ACHE), the National Association of Health Services Executives (NAHSE), the Institute for Diversity in Healthcare Management (IFD), the National Forum for Latino Healthcare Executives, and the Asian Health Care Leaders Association released a study in 2009 that measured the representation of black non-Hispanics, Hispanics, women, and other minorities in health care executive leadership roles. This study was a follow up to similar studies completed in 1992, 1997, and 2002. The study, completed in 2008, was based on a random-sample survey of 1,515 health care executives. Respondents worked in a variety of settings—hospitals, health care–provider organizations, government health agencies, and consulting and educational institutes (see **Table 2–4**).

Although the results of the 1997 study reflected improvements in diversity over the 1992 study (see: www.ache.org—Race and Ethnic Study 2002), the 2002 and 2008 results indicated that the health care industry did not do as well in promoting minorities and women in chief executive officer (CEO) and chief operating officer (COO)/senior vice president positions. In the 2008 ACHE study, as noted by the authors of the study (p. 12) and reflected in **Tables 2–4** and **2–5**, 34 percent of CEOs are white men, compared to 28 percent of them being Hispanic men, 16 percent black men, and 5 percent Asian men. However, these disparities are not apparent among women, where all racial/ethnic groups hold between 10 and 13 percent of CEO positions. When all senior executive positions are considered, including chief executive officer and chief operating officer/senior vice president, the proportion of white men in such positions continues to exceed that of minority men. However, among women, a higher proportion of Hispanic women than others are in senior executive positions. The two factors of race/ethnicity and gender are evident especially when comparing blacks and whites. For both blacks and whites, only about half as many women attained CEO or COO/senior vice president posts as their male counterparts.

In the 2013–2014 Benchmarking Survey by the Institute of Diversity, the results highlighted that while there was some limited increase in the diversity of hospitals' leadership and governance, more positive movement is needed. The study reported that minorities composed:

- 14 percent of hospital board members (unchanged from 2011)
- 12 percent of executive leadership positions (unchanged from 12 percent in 2011)
- 17 percent of first- and mid-level management positions (up from 15 percent in 2011)

Dreachslin and Curtis (2004) noted that career advancement of women and racially/ethnically diverse individuals in health care management was characterized by: (1) underrepresentation, especially in senior-level management positions; (2) lower compensation, even controlling for education and experience; and (3) more negative perceptions of equity and opportunity in the workplace. The researchers identified three areas that are key organization-specific factors for shaping career outcomes for women and racially/ethnically diverse

9781284083903_CH02_017_048.indd 34

Table 2–4 American College of Healthcare Executives 2008 Diversity Study

Population, Sample, and Response Rates

	2002					2008			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
Population	2,033	13,601	449	240	153	2,761	16,929	650	586
Sample	1,573	1,608	449	24	153	1,554	1,602	633	582
Response	779	215	118	68		492	654	250	237
Response Rate (%)	33.4	48.4	47.9	49.2	44.4	31.7	40.8	39.5	40.7
Analyzed	742	204	114	64		436	641	219	219
Males	359	125	65	37		205	321	130	119
%	44.7	48.4	61.3	57	57.8	47	50	59	54
Females	383	79	49	27		231	320	89	100
%	55.3	51.6	38.7	43	42.2	53	50	41	46

SOURCE: American College of Healthcare Executives. Reprinted with permission.

Table 2–4 American College of Healthcare Executives 2008 Diversity Study

Position by Race/Ethnicity and Year (Males)[a]

	2002					2008			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
CEO	19%	37%	23%	11%	32%	16%	34%	28%	5%
COO/Senior Vice President	25	25	24	23	14	23	22	15	17
Vice President	24	19	23	20	16	20	22	20	19
Department Head	22	10	20	31	30	27	14	22	31
Department Staff/ Other	11	9	10	15	8	13	7	15	29
	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(216)	(355)	(123)	(65)	(37)	(205)	(321)	(130)	(118)

[a] Responses may not total to 100 because of rounding.
Reproduced from American College Of Healthcare Executives with permission.

28/07/15 2:30 PM

9781284083903_CH02_017_048.indd 35

Table 2–5 American College of Healthcare Executives 2008 Diversity Study

Position by Race/Ethnicity and Year (Females)[a]

	2002					*2008*			
	Black	*White*	*Hispanic*	*Asian*	*Native American*	*Black*	*White*	*Hispanic*	*Asian*
CEO	11%	13%	9%	9%	12%	10%	13%	12%	10%
COO/Senior Vice President	15	27	16	15	16	10	18	25	11
Vice President	19	28	24	17	8	16	26	12	18
Department Head	39	19	32	34	44	39	25	27	25
Department Staff/ Other	17	14	20	26	20	25	17	23	35
	100%	100%	100%	100%	100%	100%	100%	100%	100%
n	(266)	(381)	(76)	(47)	(25)	(231)	(320)	(89)	(99)

[a] Responses may not total to 100 because of rounding.
Reproduced from American College Of Healthcare Executives with permission.

28/07/15 2:30 PM

individuals: (1) leadership and strategic orientation (i.e., senior management's commitment to successful implementation of diversity initiatives), (2) organizational culture/climate (i.e., the depth and breadth of the organization's strategic commitment to diversity leadership and cultural competence), and (3) human resources practices (i.e., establishing best practices in advancing the management careers of women and racially/ethnically diverse individuals, such as formal mentoring programs, professional development, work/life balances, and flexible benefits).

On the basis of Dreachslin's and others' research, the NCHL, ACHE, IFD, and the American Hospital Association developed the Diversity and Cultural Proficiency Assessment Tool for Leaders (see **Exhibit 2–3**). The assessment tool begins the process of developing a cultural awareness for the organization's workforce. Going forward, managers will need to develop models that establish benchmarks for cultural competence to enable their organizations to develop competent interventions, thereby improving the quality of health care (Betancourt, Green, & Carrillo, 2002).

Exhibit 2–3 A Diversity and Cultural Proficiency Assessment Tool for Leaders

CHECKLIST

As Diverse as the Community You Serve	YES	NO
• Do you monitor at least every three years the demographics of your community to track change in gender and racial and ethnic diversity?	____	____
• Do you actively use these data for strategic and outreach planning?	____	____
• Has your community relations team identified community organizations, schools, churches, businesses, and publications that serve racial and ethnic minorities for outreach and educational purposes?	____	____
• Do you have a strategy to partner with them to work on health issues important to them?	____	____
• Has a team from your hospital met with community leaders to gauge their perceptions of the hospital and to seek their advice on how you can better serve them, in both patient care and community outreach?	____	____
• Have you done focus groups and surveys within the past three years in your community to measure the public's perception of your hospital as being sensitive to diversity and cultural issues?	____	____
• Do you compare the results among diverse groups in your community and act on the information?	____	____
• Are the individuals who represent your hospital in the community reflective of the diversity of the community and your organization?	____	____
• When your hospital partners with other organizations for community health initiatives or sponsors community events, do you have a strategy in place to be certain you work with organizations that relate to the diversity of your community?	____	____

Exhibit 2–3 (Continued)

	YES	NO
• As a purchaser of goods and services in the community, does your hospital have a strategy to ensure that businesses in the minority community have an opportunity to serve you?	____	____
• Are your public communications, community reports, advertisements, health education materials, websites, etc. accessible to and reflective of the diverse community you serve?	____	____
Culturally Proficient Patient Care		
• Do you regularly monitor the racial and ethnic diversity of the patients you serve?	____	____
• Do your organization's internal and external communications stress your commitment to culturally proficient care and give concrete examples of what you are doing?	____	____
• Do your patient satisfaction surveys take into account the diversity of your patients?	____	____
• Do you compare patient satisfaction ratings among diverse groups and act on the information?	____	____
• Have your patient representatives, social workers, discharge planners, financial counselors, and other key patient and family resources received special training in diversity issues?	____	____
• Does your review of quality assurance data take into account the diversity of your patients in order to detect and eliminate disparities?	____	____
• Has your hospital developed a "language resource," identifying qualified people inside and outside your organization who could help your staff communicate with patients and families from a wide variety of nationalities and ethnic backgrounds?	____	____
• Are your written communications with patients and families available in a variety of languages that reflects the ethnic and cultural fabric of your community?	____	____
• Depending on the racial and ethnic diversity of the patients you serve, do you educate your staff at orientation and on a continuing basis on cultural issues important to your patients?	____	____
• Are core services in your hospital such as signage, food service, chaplaincy services, patient information, and communications attuned to the diversity of the patients you care for?	____	____
• Does your hospital account for complementary and alternative treatments in planning care for your patients?	____	____
Strengthening Your Workforce Diversity		
• Do your recruitment efforts include strategies to reach out to the racial and ethnic minorities in your community?	____	____
• Does the team that leads your workforce recruitment initiatives reflect the diversity you need in your organization?	____	____
• Do your policies about time off for holidays and religious observances take into account the diversity of your workforce?	____	____

(*continues*)

Exhibit 2–3 (Continued)

	YES	NO
• Do you acknowledge and honor diversity in your employee communications, awards programs, and other internal celebrations?	____	____
• Have you done employee surveys or focus groups to measure their perceptions of your hospital's policies and practices on diversity and to surface potential problems?	____	____
• Do you compare the results among diverse groups in your workforce? Do you communicate and act on the information?	____	____
• Have you made diversity awareness and sensitivity training available to your employees?	____	____
• Is the diversity of your workforce taken into account in your performance evaluation system?	____	____
• Does your human resources department have a system in place to measure diversity progress and report it to you and your board?	____	____
• Do you have a mechanism in place to look at employee turnover rates for variances according to diverse groups?	____	____
• Do you ensure that changes in job design, workforce size, hours, and other changes do not affect diverse groups disproportionately?	____	____
Expanding the Diversity of Your Leadership Team		
• Has your Board of Trustees discussed the issue of the diversity of the hospital's board? Its workforce? Its management team?	____	____
• Is there a Board-approved policy encouraging diversity across the organization?	____	____
• Is your policy reflected in your mission and values statement? Is it visible on documents seen by your employees and the public?	____	____
• Have you told your management team that you are personally committed to achieving and maintaining diversity across your organization?	____	____
• Does your strategic plan emphasize the importance of diversity at all levels of your workforce?	____	____
• Has your board set goals on organizational diversity, culturally proficient care, and eliminating disparities in care to diverse groups as part of your strategic plan?	____	____
• Does your organization have a process in place to ensure diversity reflecting your community on your Board and subsidiary and advisory boards?	____	____
• Have you designated a high-ranking member of your staff to be responsible for coordinating and implementing your diversity strategy?	____	____
• Have sufficient funds been allocated to achieve your diversity goals?	____	____
• Is diversity awareness and cultural proficiency training mandatory for all senior leadership, management, and staff?	____	____
• Have you made diversity awareness part of your management and board retreat agendas?	____	____
• Is your management team's compensation linked to achieving your diversity goals?	____	____

Exhibit 2–3 (Continued)

	YES	NO
• Does your organization have a mentoring program in place to help develop your best talent, regardless of gender, race, or ethnicity?	____	____
• Do you provide tuition reimbursement to encourage employees to further their education?	____	____
• Do you have a succession/advancement plan for your management team linked to your overall diversity goals?	____	____
• Are search firms required to present a mix of candidates reflecting your community's diversity?	____	____

Reprinted with permission of the American Hospital Association. Strategies for Leadership: Does Your Hospital Reflect the Community It Services? http://www.aha.org/aha/content/2004/pdf/diversitytool.pdf

In order to best serve their patient base, health care organizations and providers must be willing to invest the time, money, and effort needed to educate all their employees. Educating senior staff is important, but so is educating the entire health care workforce. Wilson-Stronks and Murtha (2010), Cejka Search and Solucient (2005), and Kochan et al. (2003) have linked the effects of diversity to business performance. Kochan and colleagues (2003) concluded that the impact of diversity is dependent upon the following factors: organizational culture, human resource practices, and strategy. In other words, the impact of diversity is directly related to the organization's ability to walk their talk and can have a negative impact if not followed. For example, the Witt/Kieffer's 2011 national survey of 454 health care professionals, with 54 percent representing senior executives, provides a deeper understanding of how diversity is connected to measurable business benefits:

- Patient satisfaction: Nearly two-thirds (62 percent) believe cultural differences improve patient satisfaction.
- Successful decision-making: More than half (57 percent) believe that cultural differences support successful decision-making.
- Strategic goals: More than half of these respondents (54 percent) acknowledge that diversity recruiting enables the organization to reach its strategic goals.
- Clinical outcomes: Nearly half (46 percent) believe diversity improves clinical outcomes.

Dreachslin (2007) reinforces the need for mass customization of diversity practices to be inclusive of disparities that are represented within the communities that health care organizations serve. In order to actively support business strategy, organizations will need to provide employees with skills that are inclusive of conflict-management skills, self-awareness, understanding of cultural differences, validation of alternative points of view, and methods to manage bias through effective human resource training and development.

For health care managers to transform their organizations into an inclusive culture where all employees feel the opportunity to reach their full potential, Guillory (2004, pp. 25–30) recommended a 10-step process:

1. Development of a customized business case for diversity for your organization. In other words, how does diversity relate to the overall success of the organization?
2. Education and training for your staff to develop an understanding of diversity, its importance to your organization's success, and diversity skills to apply on a daily basis.
3. Establishment of a baseline by conducting a comprehensive cultural survey that integrates performance, inclusion, climate, and work/life balance.
4. Selection and prioritization of the issues that lead to the greatest breakthrough in transforming the culture.
5. Creation of a three- to five-year diversity strategic plan that is tied to organizational strategic business objectives.
6. Leadership's endorsement of and financial commitment to the plan.
7. Establishment of measurable leadership and management objectives to hold managers accountable to top leadership for achieving these objectives.
8. Implementation of the plan, recognizing that surprises and setbacks will occur along the way.
9. Continued training in concert with the skills and competencies necessary to successfully achieve the diversity action plan.
10. Survey one to one-and-a-half years after initiation of the plan to determine how inclusion has changed.

Reproduced from Guillory, W. A. (2004). The roadmap to diversity, inclusion, and high performance. Healthcare Executive, 19(4), 24–30.

Dreachslin (2007) stresses the need for organizations to "manage" diversity and invest in professional development so that team members have the tools needed to navigate their differences and effectively manage their bias. As Dreachslin notes, "if left unmanaged, demographic diversity will interfere with team functioning."

THE FUTURE WORKFORCE

For the first time in modern history, our workforce consists of four separate generations working side by side—and the differences among them are one of the greatest challenges facing managers today (Wasserman, 2007). Bonnie Clipper (2012, p. 45), author of *The Nurse Manager's Guide to an Intergenerational Workforce*, provides a humorous example for understanding the generations' differences.

> A nurse manager desperate for more staff, telephones four nurses to ask whether they will pull an extra shift:
>
> The first nurse says, "What time do you need me?"
> The second nurse says, "Call me back if you can't find anyone else."

The third nurse says, "How much will you pay me?"
The fourth nurse says, "Sorry, I have plans. Maybe next time."

Adapted from Stokowski, L. A. (2013). The 4-generation gap in nursing. Medscape. Available at: www.medscape.com/viewarticle/781752

These different reponses are typical of the four different generations of nurses currently working side by side at the bedside. The first response was from the traditionalist generational cohort. This generation, born between 1925 and 1942, is typically characterized as dedicated, hardworking, and loyal. The second response is from the Baby Boomer generation, those born between 1943 and 1960 who are viewed as optimistic, productive, and workaholics. The third response is from Generation X, born between 1961 and 1981, typically referred to as cynical, independent, and informal. The fourth response is reflective of the Millennial generational cohort, born between 1982 and 2000, which is viewed as confident, inpatient, and social. Becton, Walker, and Jones-Farmer (2014) point out that although much has been written about their differences, there still remains a gap in our understanding of each generational cohort's values and beliefs. As such, generational differences may best be explained by "age, life stage, or career stage effects" (Becton, Walker, & Farmer, 2014, p. 176).

As part of diversity management, health care managers need to devise strategies for attracting younger workers to enter the health care field while maintaining positive relationships with older workers. For example, Barney (2002, p. 83) points out that Generation X workers want "managers who listen, consider their ideas, and treat them as peers. They want to be part of the decision-making process and want flexibility in their work environment because they value their time and freedom."

What about the Millennials, sometimes referred to as Generation Y? Although this generational cohort has only recently begun to enter the workforce, Millennials will be the fastest-growing segment of the working population—they grew from 14 percent of the workforce to 21 percent over the past four years, to nearly 32 million workers (Armour, 2005). Although it is impossible to generalize about the wants and needs of millions of people in each generation, workplace experts tend to use the following characteristics to describe the Millennials (Martin & Tulgan, 2006):

- High expectations of self: They aim to work faster and better than other workers.
- High expectations of employers: They want fair and direct managers who are highly engaged in their professional development.
- Ongoing learning: They seek out creative challenges and view colleagues as vast resources from whom to gain knowledge.
- Immediate responsibility: They want to make an important impact on day one.
- Goal oriented: They want small goals with tight deadlines so they can build up ownership of tasks.

In addition to the younger workers, health care managers must also consider the needs of older workers. For example, in a Robert Wood Johnson

Foundation study, Hatcher and colleagues (2006) suggested that hospitals seeking to recruit and retain older nurses need to implement strategies, such as flexible work hours, increased benefits, newly created professional roles, and an atmosphere of respect for nurses.

Generational diversity poses challenges for today's and tomorrow's employers. Younger workers have a strong need for immediate feedback, workers now in their 30s and 40s demand greater work–life balance and flexibility, and older workers expect increased benefits and professionalism. With a multigenerational workforce, employers will need to develop age-diversity training programs for their managers so they can better understand the needs and expectations of each generation (Martin & Tulgan, 2006).

SUMMARY

Health care organizations need to be flexible to change and meet diversity challenges. The greatest barrier to the industry's success may be its inability to understand and appreciate the increasing diversity within our population, whether relating to patients or employees. As Kochan and colleagues (2003, p. 18) related,

> Diversity is a reality in labor markets and "customer" markets today. To be successful in working with and gaining value from this diversity requires a sustained, systemic approach and long-term commitment. Success is facilitated by a perspective that considers diversity to be an opportunity for everyone in an organization to learn from each other how better to accomplish their work and an occasion that requires a supportive and cooperative organizational culture as well as group leadership and process skills that can facilitate effective group functioning. Organizations that invest their resources in taking advantage of the opportunities that diversity offers should outperform those that fail to make such investments.

Similarly, Dobson (2012) states that although more research is needed, it makes good business sense for organizations to invest in leadership diversity. She argues that there are three interrelated strategies for organizations to consider: (1) linking diversity with performance, (2) linking investments in diversity to financial outcomes and organizational metrics of success, and (3) making organizational leadership responsible for cultural competence as a performance measure. When operational measures are connected with a culturally competent organization, the results will be a reduction in health disparities, increased patient satisfaction, and a more engaged workforce.

DISCUSSION QUESTIONS

1. Discuss what the term "diversity" means.
2. Explain the meaning of cultural competency.

3. What do we mean when we say "diversity management"?
4. Explain why and how changes in U.S. demographics affect the health care industry.

EXERCISE 2–1

You have been asked to join the hospital's task force for developing a plan to increase the organization's workforce diversity from its current 20 percent level to 40 percent over the next five years. How does your task force define diversity? What recommendations would you make as a member of the task force?

EXERCISE 2–2

In 2012, the Alliance of Aging Research established the Healthspan Campaign, a coalition of organizations committed to solving the challenges brought about by the aging of the American population. With each passing year, the percentage of people in the United States—and much of the world—over age 65 increases. This "Silver Tsunami" is expected to bring a flood of chronic disease and disabilities due to aging that could overwhelm the health care systems of many nations. Watch the films *The Healthspan Imperative* and *What Is the Silver Tsunami?* at www.healthspancampaign.org. Discuss the effect of the aging population on our health system and present recommendations for how these challenges could be addressed.

EXERCISE 2–3

Visit the Hofstede Centre (http://geert-hofstede.com/countries.html) and review the scores by country for the various cultural dimensions that Hofstede identified. In light of these scores, think about some interactions you've had with people (colleagues, patients, friends, etc.) born and raised in other countries. Do your interactions make more sense given this newly found insight?

EXERCISE 2–4

View the video titled *Improving Patient-Provider Communication: Joint Commission Standards and Federal Laws* at www.jointcommission.org/multimedia/improving-patient-provider-communication---part-1-of-4/. The video was a joint project of The Joint Commission and the U.S. Department of Health & Human Services (HHS) Office for Civil Rights to support language access in health care organizations.

With diverse patient populations come language translation issues. Medical interpretation is a challenge facing most health organizations. Medical interpretation and translation services are costly. You are a member of your

hospital's task force challenged to establish customer-focused, cost-efficient communication programs. What recommendations would you make as a member of the task force?

EXERCISE 2–5

In December 2012, the American College of Healthcare Executives released its fifth report in a series of research surveys designed to compare the career attainments of men and women health care executives. View this report, titled *A Comparison of the Career Attainments of Men and Women Healthcare Executives: 2012,* at www.ache.org. In small groups, discuss the changes (if any) regarding women advancing to senior leadership positions that have occurred in the health care industry since the previous report in 2006.

EXERCISE 2–6

In April 2013, *Modern Healthcare* published its fourth biennial recognition of the Top 25 Women in Healthcare. The previous lists appeared in 2005, 2007, and 2009 and can be found on ModernHealthcare.com under "Recognitions." In small groups, discuss the changes (if any) over the past nine years of the selected awardees population (i.e., employed in what sectors of the health industry, what positions do/did they hold, race/ethnicity groups, and so on).

REFERENCES

Alliance for Aging Research. (2003). Ageism: How healthcare fails the elderly. Available at: www.agingresearch.org

American College of Healthcare Executives. (2008). A race/ethnic comparison of career attainments in healthcare management, Summary Report—2008. Available at: www.ache.org

American Nurses Association, Cultural Diversity in Nursing Practice, 1991. www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/prtetcldv14444.html

Armour, S. (2005, November 6). Generation Y: They arrived at work with an attitude. *USA Today*. Available at: www.usatoday.com/money/workplace/2005-11-06-gen-y_x.htm

Association of American Medical Colleges. (2005). Cultural competence education. Available at: www.aamc.org/download/54338/data/culturalcomped.pdf

Barney, S. M. (2002). A changing workforce calls for twenty-first century strategies. *Journal of Healthcare Management*, *47*(2), 61–65.

Beach, M. C., Saha, S., & Cooper, L. A. (2006). The role and relationship of cultural competence and patient-centeredness in health care quality. The Commonwealth Fund. Available at: http://www.commonwealthfund.org

/publications/fund-reports/2006/oct/the-role-and-relationship-of-cultural-competence-and-patient-centeredness-in-health-care-quality

Becton, J. B., Walker, H. J., & Jones-Farmer, A. (2014). Generational differences in workplace behavior. *Journal of Applied Social Psychology*, *44*(3), 175–189.

Betancourt, J., Green, A. R., & Carrillo, E. (2002). Cultural competence in health care: Emerging frameworks and practical approaches. The Commonwealth Fund. Available at: www.commonwealthfund.org/usr_doc/betancourt_culturalcompetence_576.pdf?section=4039

Bowling, A. (2007). Honour your father and mother: Ageism in medicine. *British Journal of General Practice*, *57*(538), 347–348.

Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic racial health disparities? A review and conceptual model. *Medical Care Review*, *57*(Suppl. 1), 181–217.

Butler, R. (1969). Age-ism: Another form of bigotry. *The Gerontologist*, *9*, 243–246.

Ceijka Search and Solucient, LLC. (2005). Hospital CEO Leadership Survey. St. Louis, MO: Ceijka Search and Solucient, LLC.

Clipper, B. (2012). *The nurse manager's guide to an intergenerational workforce*. Indianapolis, IN: Sigma Theta Tau International.

Commonwealth Fund. (2002). International health policy survey of adults with health problems. Available at: www.cmwf.org

Commonwealth Fund. (2003). Worlds apart: A film series on cross-cultural health care. Available at: www.cmwf.org

Dobson, E. (2012). Setting the stage for a business case for leadership diversity in healthcare: history, research, and leverage. *Journal of Healthcare Management*, *57*(1), 35–46.

Dreachslin, J. L. (1998). Conducting effective focus groups in the context of diversity: Theoretical underpinnings and practical implications. *Qualitative Health Research*, *8*(6), 813–820.

Dreachslin, J. L. (2007). Diversity management and cultural competence: Research, practice and the business case. *Journal of Healthcare Management*, *52*(2), 79–86.

Dreachslin, J. L., & Curtis, E. F. (2004). Study of factors affecting the career advancement of women and racially/ethnically diverse individuals in healthcare management. *Journal of Health Administration Education*, *21*(4), 441–484.

Fadiman, A. (1998). *The spirit catches you and you fall down*. New York, NY: Farrar, Straus and Giroux.

Goode, T. & Jones, W. (2004). Increasing awareness and implementation of cultural competence principles in health professions education. *Journal of Allied Health*, *29*(4), 241–245.

Guillory, W. A. (2004). The roadmap to diversity, inclusion, and high performance. *Healthcare Executive*, *19*(4), 24–30.

Hatcher, B., Bleich, M. R., Connolly, C., Davis, K., O'Neill Hewlett, P., & Stokley Hill, K. (2006). *Wisdom at work: The importance of the older and experienced nurse in the workplace*. Princeton, NJ: The Robert Wood Johnson Foundation. Available at: www.rwjf.org/files/publications/other/wisdomatwork.pdf

Hofstede, G. (1983). The cultural relativity of organizational practices and theories. *Journal of International Business Studies*, *14*(2), 75–89.

Hofstede, G. (1991). *Cultures and Organizations: Software of the Mind*. London, UK: McGraw-Hill.

Hofstede, G., Van Deusen, C. A., Mueller, C. B., & Charles, T. A. (2002). What goals do business leaders pursue? A study in fifteen countries. *Journal of International Business Studies*, *33*(4), 785–803.

Howard, C., Andrade, S. J., & Byrd, T. (2001). The ethical dimensions of cultural competence in border healthcare settings. *Family and Community Health*, *23*(4), 36–49.

Howden, L. M., & Meyer, J. A. (2011). Age and sex composition: 2010. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, Washington, DC.

Humes, K.R., Jones, N.A. & Ramirez, R.R. (2011). Overview of race and Hispanic origin: 2010. U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, Washington, DC.

Human Rights Campaign (2014). Healthcare Equality Index. Available at: http://www.hrc.org/hei

Institute for Diversity in Health Management. (2014). About the Institute. Available at: www.diversityconnection.org/diversityconnection/about-us/About-the-Institute.jsp

Institute of Medicine. (2004). *In the nation's compelling interest: Ensuring diversity in the health care workforce*. Washington, DC: National Academy Press.

Kochan, T., Bezrukova, R., Jackson, A., Jehn, K., Leonard, D., & Thomas, D. (2003). The effects of diversity on business performance: Report of the diversity research network. *Human Resource Management*, *42*(5), 3–21.

Kundhal, K. K. (2003). Cultural diversity: An evolving challenge to physician-patient communication. *Journal of the American Medical Association*, *289*(1), 94.

Martin, C., & Tulgan, B. (2006). *Managing the generation mix* (2nd ed.). Amherst, MA: HRD Press.

Motwani, J., Hodge, J., & Crampton, S. (1995). Managing diversity in the healthcare industry. *Healthcare Supervisor*, *13*(3), 16–25.

Nahavandi, A., & Malekzadeh, A. R. (1999). *Organizational behavior: The person-organization fit*. Upper Saddle River, NJ: Prentice Hall.

National Urban League. (2009). Diversity practices that work: The American worker speaks II. Available at: nul.iamempowered.com/sites/nul.iamempowered.com/files/attachments/Diversity_Practices_That_work_2009.pdf

Patel, C. (2003). Some cross-cultural evidence on whistle-blowing as an internal control mechanism. *Journal of International Accounting Research*, *2*, 69–96.

Perry, D. (2012). Entrenched ageism in healthcare isolates, ignores and imperils elders. *Aging Today*, *33*(2), 1.

Robert Wood Johnson Foundation. (2014). Improving health care by measuring it. Available at: www.rwjf.org/content/dam/farm/reports/program_results_reports/2014/rwjf412674

Svehla, T. (1994). Diversity management: Key to future success. *Frontiers of Health Services Management*, *11*(2), 3–33.

The Joint Commision. (2014). A crosswalk of the national standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care to The Joint Commission Hospital Accreditation Standards. Available at: www.jointcommission.org/assets/1/6/Crosswalk-_CLAS_-20140718.pdf

Traxler, A. J. (1980). Let's get gerontologized: Developing a sensitivity to aging. *The multi-purpose senior center concept: A training manual for practitioners working with the aging*. Springfield, IL: Illinois Department of Aging.

United Nations. (2013). World population prospects: The 2012 revision—Highlights and advance tables. New York. Available at: esa.un.org/wpp/Documentation/pdf/WPP2012_HIGHLIGHTS.pdf

United States Census Bureau. (2012). A look at the 1940 Census. Available at: www.census.gov/newsroom/cspan/1940census/CSPAN_1940slides.pdf

United States Department of Commerce, Bureau of the Census. (2003). Chartbook on trends in the health of Americans. Retrieved March 21, 2004, from InfoTrac online database.

United States Department of Commerce, Bureau of the Census. (2004). U.S. interim projections by age, sex, race, and Hispanic origin. Available at: www.census.gov/ipc/www/usinterimproj/

United States Department of Health and Human Services, Office of Minority Health [HHS OMH]. (2013). National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS Policy and Practice. Retrieved from www.thinkculturalhealth.hhs.gov

Warshaw, G. A. (2002). Academic geriatrics programs in US allopathic and osteopathic medical schools. *Journal of the American Medical Association*, *288*, 2313–2319.

Warshaw, G. A., Bragg, E. J., Thomas, D. C., Ho, M. L., & Brewer, D. E. (2006). Are internal medicine residency programs adequately preparing physicians to care for the Baby Boomers? A national survey from the Association of Directors of Geriatric Academic Programs Status of Geriatrics Workforce Study. *Journal of the American Geriatrics Society*, *54*(1), 1603–1609.

Wasserman, I. (2007). Generations working together. *Entrepreneur*. Available at: www.entrepreneur.com/article/183720

Weech-Maldonado, R., Dreachslin, J. L., Dansky, K. H., DeSouza, G., & Gatto, M. (2002). Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management*, *47*(2), 111–124.

Weech-Maldonado, R., Elliott, M. N., Schiller, C., Hall, A., Dreachslin, J. L., & Hays, R.D. (2007). Organizational and market characteristics associated with hospitals' adherence to the CLAS standards. Presentation at the APHA Annual Meeting in Washington, DC, on November 5.

Weech-Maldonado, R., Elliott, M. N., Schiller, C., Hall, A., & Hays, R. D. (2007). Does Hospitals' adherence to the CLAS standards influence diverse patients' experiences with inpatient care. Presentation at the APHA Annual Meeting in Washington, DC, on November 5.

Weil, P., & Mattis, M. (2001). Narrowing the gender gap in healthcare management. *Healthcare Executive 16*(6), 12–17.

Wilson-Stronks, A., & Mutha, S. (2010). From the perspective of CEOs: What motivates hospitals to embrace cultural competence? *Journal of Healthcare Management*, *55*(5), 339–351.

Witt/Kieffer (2011). Building the business case. Healthcare diversity leadership: A national survey report. Institute for Diversity in Healthcare Management, Institute Resource Center. Available at: www.diversityconnection.org/diversityconnection/membership/Institute-Resource-Center.jsp?fll=S12

OTHER SUGGESTED READING

Lantz, P. (2008). Gender and leadership in healthcare administration: 21st century progress and challenges. *Journal of Healthcare Management*, *53*(5), 291–304.

Institute of Medicine. (2004). In the nation's compelling interest: Ensuring diversity in the healthcare workforce. Available at: www.nap.edu/catalog/10885.html

A full list of reference texts discussing cultural beliefs and influences, issues, and how to identify/develop materials can be found on the National Center for Cultural Healing, at: www.culturalhealing.com/patientedu.htm

Information relating to Anne Fadiman's book, *The Spirit Catches You and You Fall Down*, may be viewed at: www.spiritcatchesyou.com

Learn more about how language and culture affect the delivery of quality services to ethnically diverse populations at: www.diversityrx.org