Workforce Diversity: 
A Step Toward Eliminating Health Disparities

BY GARY PUCKREIN, PH.D., EXECUTIVE DIRECTOR, NATIONAL MINORITY HEALTH MONTH FOUNDATION

Evidence of a gap in health outcomes in the United States between non-Hispanic whites and racial and ethnic minorities is simply irrefutable. Closing this gap requires increased diversity among health care workers – both clinicians and management – and increased cultural competence among all health care providers.

During President Ronald Reagan’s administration, the U.S. Department of Health and Human Services (HHS) released the pioneering study Health, United States, 1983, which documented what HHS Secretary Margaret Heckler characterized as “a continuing disparity in the burden of death and illness experienced by Blacks and other minority Americans as compared with our nation’s population as a whole.”

In 2000, Surgeon General David Satcher, who was appointed by President Bill Clinton, issued Healthy People 2010, a document that established the elimination of health disparities as an overarching national goal. In the same year, Public Law 106-525 created the National Center on Minority Health and Health Disparities within the National Institutes of Health because “there are continuing disparities in the burden of illness and death experienced by [minorities], compared to the United States population as a whole.”

In 2002, the Institute of Medicine (IOM) added its considerable prestige to the effort when it released its report Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, which states: “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as patients’ insurance status and income, are controlled.” In January 2002, HHS Secretary Tommy Thompson released an agency report that showed that “important disparities in health persist among different populations.” He took the occasion to reiterate “our goal is to eliminate disparities in health among all population groups by 2010.”

In 2004, the Sullivan Commission on Diversity in the Healthcare Workforce published Missing Persons: Minorities in the Health Professions, describing its examination of disparities and diversity in the health care system. Noting that “the lack of minority health professionals is compounding the nation’s persistent racial and ethnic health disparities,” the commission concluded “that the condition of the nation’s health professions workforce is critical and demands swift, large-scale change to protect the future health of the nation,” and made 37 recommendations to address the crisis.

Currently, several congressional bills addressing health disparities have been introduced, including one by Sen. Bill Frist (R-TN) and another by Rep. Nancy Pelosi (D-CA). The American Hos-
pital Association, the American Medical Association, the National Medical Association, the Interamerican College of Physicians and Surgeons, and the American Public Health Association have all taken up the challenge of eliminating health disparities. Some of our largest charitable foundations – for example, the Kellogg Foundation, the Robert Wood Johnson Foundation, the Commonwealth Fund and the Henry J. Kaiser Family Foundation – are investing in programs dedicated to eliminating health disparities. Bipartisan momentum is growing to eradicate this systemic problem, and diversity is central to any effective response.

The need for cultural competence and diversity in staffing is urgent, but improvements at the level of patient-provider interaction will not constitute a cure for what ails the health care system. Diversity in management and policy-making is also essential to connecting minority patients with the care that they need. Consultation with stakeholders provides important reassurance to managers and policymakers, but history shows that the experience, concerns and linkages of minority populations will not be on the agenda without the active, continuous, empowered participation of members of minority groups at the management and policy levels.

Of particular concern today is the bottleneck in the education pipeline. As the costs of higher education are rising, financial aid is falling. Economically disadvantaged people, many (if not most) of them minorities, are finding it impossible to acquire the education needed to qualify for the positions that should be opening up for them. The Sullivan Commission’s report provides an overview and specific recommendations for change. Every individual, institution and organization in the health care system must become active in advocating and providing education, training and professional advancement for minorities. Academia and the government will not remove the obstacles on their own.

As a historian, I cannot resist taking the long view. America’s minorities are about to welcome a new group. The U.S. Census Bureau projects that the non-Hispanic white population will fall below 50 percent sometime around the middle of this century. Building a system that incorporates all minorities and addresses their various needs with equal effectiveness is in the best interest of everyone’s health.

**Institute Unveils New Web Site**

We are pleased this month to announce the debut of our new logo and the relaunch of our Web site, www.diversityconnection.org. This dynamic new site, designed in partnership with the American Hospital Association, will provide our members with access to new and improved tools to help them craft the workforce of the future and stay abreast of trends and best practices in diversity management.

Features of our new Web site include:

- An enhanced Career Center, which links health care employers to the best and brightest diverse management candidates
- Diversity Solutions, a broad range of products, services and information to help our members meet their diversity goals
- The Diversity Spotlight, which celebrates the diversity accomplishments of our members and health care leaders
- And much more!

Log on now to www.diversityconnection.org and get connected to the leading strategies in health care diversity management. For more information, contact us at 312.422.2630 or Institute@aha.org.

**NEWS TO USE**

**Henry J. Kaiser Family Foundation Accepting Applications for 2007 Barbara Jordan Health Policy Scholars Program**

The Henry J. Kaiser Family Foundation, in conjunction with Howard University, has begun accepting applications for the 2007 Barbara Jordan Health Policy Scholars Program. The program, designed to honor former Congresswoman Barbara Jordan and increase the number of minority students interested in the field of health policy, places African American, Latino, American Indian/Alaska Native and Asian/Pacific Islander scholars in congressional offices in Washington, DC, for nine weeks to learn more about health policy. During their internships, scholars will participate in seminars and site visits to enrich their understanding of health policy. In addition, scholars will be required to write and present a research paper on a health policy topic of their choice. “The Barbara Jordan Health Policy Scholars Program is an exceptional opportunity for talented students to gain firsthand experience on Capitol Hill, learn about critical policy issues and undertake in-depth policy analysis projects,” said Drew E. Altman, KFF president and CEO. “I encourage all qualified students to apply to be a part of this exceptional congresswoman’s legacy as they prepare to take on leadership roles in the health policy arena.” The program is open to U.S. citizens who will be seniors or recent graduates of an accredited U.S. college or university in the fall of 2007. Candidates will be selected based on academic performance, demonstrated leadership potential and interest in health policy. Application materials, due December 15, are available online at www.bjscholars.org.

**AHRQ Seeks Cultural Competency, Health Literacy Measures for CAHPS**

The Agency for Healthcare Research and Quality seeks survey instruments or items for a new CAHPS cultural competency survey that will measure patient perspectives on the cultural awareness of health care professionals. “The addition of the CAHPS cultural competency component to the set is intended to empower consumers with quality of care information while also encouraging health professionals to provide culturally competent care,” the agency said in an October Federal Register notice. In a separate notice, the agency said it also seeks survey instruments or items to include in a planned health literacy module to the CAHPS, intended “to provide information to health plans, hospitals, clinicians, group practices, and other interested parties regarding quality of health information delivered to patients.”

**Palomar Pomerado Health Awarded $150,000 Grant to Increase Minority Middle School Students’ Interest in Health Care Jobs**

Palomar Pomerado Health, a two-hospital system near San Diego, has been awarded a three-year, $150,000 grant by the California Wellness Foundation to increase diversity in the health care workforce through its GEAR UP Program, which...
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educates middle school students about professional job opportunities in the health care field. While enrollment in the program, which has prepared more than 6,000 students for college since 1999, is open to students from various backgrounds, the grant is intended to increase Latino and Native American participation in particular. Brad Wiscans, director of grant services, said the goal of the grant is to help ensure that the California health care workforce reflects the population it serves. A recent study by the Sullivan Commission on Diversity in Healthcare Workforce found that Latinos represent less than 5 percent of licensed physicians and less than 8 percent of licensed dentists in California.

University of Buffalo Receives Grant to Create Cultural Competency Training Program

The University of Buffalo School of Medicine and Biological Sciences received a $560,000 grant from the National Heart, Lung and Blood Institute to create a cultural competency training program. Students in the School of Health Professions and the School of Nursing will benefit from training created under the five-year “Medical Training in Diversity” grant. Dr. Kimberly Griswold, an associate professor of family medicine and psychiatry, and Judith Schipengrover, an educational research consultant, will oversee the design of the program, which will include a variety of case studies drawn from the Buffalo area. In particular, the case studies will focus on the area’s refugee and lower-income populations.

Kaiser Permanente’s 29th Annual Diversity Conference Tackles Cutting-edge Diversity Issues

Kaiser Permanente in October held its 29th annual Diversity Conference, “Global Diversity: A Call to Action,” in Universal City, CA, examining the impact of global trends like immigration on health care in the United States. The two-and-a-half day conference included expert panels on a host of diversity issues, including culturally competent care, workforce diversity and marketing to diverse populations. In addition, topics such as generational diversity and religious tolerance also were discussed. “Kaiser Permanente is committed to making diversity a reality in health care through the development of culturally competent care and linguistic proficiency programs,” Ronald Knox, vice president and chief diversity officer, said. “This year’s conference offered an extraordinary opportunity to address global trends by understanding our connection to them.” Kaiser Permanente was awarded the 2006 National Committee for Quality Assurance “Recognizing Innovation in Multicultural Health Care Award” for its Qualified Bilingual Staff Model and Health Care Interpreter Certificate Program, two programs designed to address the lack of qualified health care interpreters.

Hispanic Dental Association Examines Diversity, Cultural Competence

The Hispanic Dental Association’s 14th Annual Meeting continued on page 4

Fred’s Corner

By Fred D. Hobby, President and CEO Institute for Diversity in Health Management

The Language Gap Widens

As immigrant and migrant populations in North America continue to grow, hospitals are noticing an increase in the diversity of their patient populations. Many of these populations have limited English proficiency. This increase in limited- and non-English speaking patients has created mounting safety, quality and cost challenges for hospitals. While most have adopted some means of communicating with patient populations with limited-English skills, the language gap ironically has widened.

There are several reasons for this unfortunate and liability-producing situation. Despite the LEP Guidelines published on August 30, 2000, some facilities continue to use patients’ children and family members as interpreters, often claiming there is no one else available, or that the cost of using an agency interpreter is prohibitive. Hospitals that use these informal interpreters not only violate the patient’s right to confidentiality, but run the risk of miscommunication: individuals not trained in medical terminology often misinterpret terms or insert their own personal judgments into the conversation.

Some hospitals have opted to use their bilingual employees as medical interpreters in order to expedite throughput and avoid cost. This gives the appearance of access to care and sensitivity to language barriers, but instead contributes to the growth of the language gap. Untrained interpreters are, in fact, not qualified to participate in the diagnostic and invasive procedures being provided by hospitals.

While bilingual employees may assist with activities such as the patient enrollment processes, their involvement in the care delivery process is contraindicated. There is plenty of evidence that links poor outcomes with poor communication. Without professionally trained and “qualified” interpreters, hospitals can expect to perform unnecessary tests, have an increase in the average length of stay, and experience a decrease in patient satisfaction when treating non-English speaking patients. Poor communication can be as hazardous as no communication.

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finished the year with improved morale and under budget.

How can health care embrace the leadership imperative to increase diversity among health care managers?

“Leadership and learning are indispensable of each other.” This was noted in a speech to be delivered by John F. Kennedy in Dallas. This reality has the potential to be the cornerstone of any infrastructure that realizes the potential of addressing key leadership challenges … tomorrow’s leaders must transform and deploy the vision of an organization through strategic thinking and diversity initiatives … we need to be proactive rather than reactive. My organization is building a strong foundation for improving the quality of our health services … we have a comprehensive strategy to recruit Alaska Native/American Indian people.

What advice would you give to racially and ethnically diverse individuals seeking to enter health care administration?

Evaluate what you value the most and where your desire may lead. What are your strengths? Where do you need improvement? As an Athabascan Indian, raised in a traditional household, it has been and still is difficult for me to articulate and sell my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and my assets of skills and abilities. This is considered boasting and
Programs Help Prepare Minority Mid-careerists for Senior Leadership Positions

Derrick Jones had worked as a support services administrator at Catholic Health Initiative’s (CHI) Memorial Hospital in Chattanooga, TN, for more than four years and wanted to move into a senior-level position. He began searching for programs that could help prepare him to achieve his goal of becoming a vice president of operations.

He discovered CHI’s nascent Executive Diversity Fellowship, a one-year program that places diverse, highly-qualified candidates in executive-level positions within the CHI system. Through customized personal development, leadership training and mentoring at a local hospital, regional system and the national level, the program seeks to expose fellows to a broad array of experiences that will prepare them for senior-level positions.

After being accepted into the program in February 2003, Jones went to the CHI’s offices in Denver and charted his year-long program, focusing on experiences that would prepare him to become a vice president of operations. “It was a really neat opportunity to chart a course for my own career,” Jones said. “I was basically able to start with the end in mind from day one.”

He was placed for five months in one of CHI’s regional offices in northern Kentucky under the mentorship of Jim Kaskie, senior vice president of operations. There he was tasked with integrating the recently acquired Beria Hospital, a 25-bed critical access hospital serving 19,000 families, into the system. Jones helped bring Beria’s 275 employees into the CHI culture and integrated the information technology and financial systems, the governance board and medical bylaws with those of CHI. “That was a really good experience to basically see from the ground up hospital acquisitions, the due diligence process, as well as operations, consolidation and the transition,” Jones recalled.

Jones then spent five months at St. Joseph Hospital in Lexington, KY, under the mentorship of CEO Bill Hendrickson, where he worked to expand the hospital’s home health agency. He also spent two months with then Chief Operating Officer Kevin Lofton, gaining insight into CHI’s organizational structure, how the system allocates capital and its mergers and acquisitions strategy.

After the fellowship ended, CHI placed Jones as a vice president for clinical services at St. Joseph’s, where he oversaw the radiology, laboratory, sleep center, diagnostic center and home health departments for a year. He was promoted last January to vice president of operations at St. Joseph’s, where one of his primary tasks is overseeing Beria Hospital, the facility he helped transition to CHI during his fellowship experience.

Jones, whose long-term goal is to become a CEO for one of CHI’s market-based organizations, considers the Executive Diversity Fellowship “a great opportunity to meet a lot of smart people and view some very neat leadership styles. It was a great year to focus on my own sort of leadership development and kind of pick up the best of the best of leaders throughout the country.”

CHI’s Executive Diversity Fellowship program is one of a handful of programs nationwide specifically targeted toward mid-level minority careerists in health care administration. Applicants for the program must have a minimum of three years management experience. CHI networks extensively, including through the National Association of Health Services Executives, to find highly-qualified candidates and awards a fellowship every 18 months.

“The mid-level program is a distinctive one because it really gives someone who has already developed a proven track record over a three-to-five year period of time a real breakthrough opportunity in terms of their own careers,” said Mike Fordyce, chief administrative officer at CHI.

CHI initially sought to target the program toward minorities in the early stages of their careers, but opted for mid-careerists after learning that many promising candidates often plateau at the mid-management level after advancing early in their careers. “There can be a significant challenge for health care executives who are of a gender or ethnic/racial minority,” Fordyce said. “They don’t seem to have a problem getting their first job, but they seem to hit a wall in terms of getting into the vice-president level and above after three to five years.”

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U.S.V.I. Health Professionals Address Diversity, Disparities

Health professionals in the U.S. Virgin Islands last month came together to tackle the issues of diversity and health disparities. The second annual conference, titled “Cultural Diversity and Health Disparities in the Virgin Islands: Challenges for the Health Care System,” was sponsored by the UVI Caribbean EXPORT Center (EXPORT stands for “Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training”) and attended by health professionals from both the islands and the continental U.S. Participants explored options for expanding health insurance coverage, health screenings and the pool of minority nurses. The conference, held in Charlotte Amalie, also addressed health disparities among the islands’ minority populations.
The vast majority of hospitals – 80 percent – provide critical translation and interpretation services to patients with limited English proficiency. But only 3 percent are reimbursed for these services, according to a survey released this fall by the Health Research & Educational Trust (HRET), an AHA affiliate, and the National Health Law Program, which funded the survey.

The survey found that hospitals offer a variety of language services to communicate with patients who speak limited English, including staff interpreters, telephone services and bilingual clinical staff. About half of the survey’s respondents said they have no means of identifying patients who need language services before they arrive at the hospital, and 41 percent of hospitals said they need additional tools and training.

Providing language services is important – studies have shown that communication barriers between doctors and patients can contribute to disparities in health care treatment and outcomes for minority patients. Studies suggest that these cultural barriers also can lead to doctors ordering unnecessary tests, and patients spending more time in hospital emergency departments.

“The 2000 Census called attention to the increasing number and diversity of individuals with limited English proficiency in the United States,” Romana Hasnain-Wynia, HRET’s vice president for research and lead author of the study, said at a Washington, DC briefing. “Most hospitals are trying to meet their needs, but cannot do it alone. Hospitals need help.”

Christina Krasny, WakeMed Health and Hospitals’ manager of interpretation and translation services in Raleigh, NC, described her hospital’s efforts to improve services for patients with limited English proficiency (see sidebar for more information). She recommended that all hospitals appoint a staff person to oversee interpretation and translation services.

“Without a dedicated staff person, a hospital will not be able to develop a language assistance program that touches every aspect of the organization, from signs and maps to interpretations and staff training,” she said.

For more on the report, go to www.hret.org/languageservices.

Fred’s Corner

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Language differences, like cultural differences, are safety and quality issues that increase cost and contribute to disparities in medical outcomes if they are not systematically addressed. As hospitals continue to find ways to address the challenges associated with language and cultural differences within the diverse patient populations we are privileged to serve, the appropriate platforms for improvement are quality and safety.

We need to understand that using the patient’s bilingual children, family members and friends does not close the language gap. The use of untrained medical interpreters, whether they come from a contracted telephonic service, or physicians who spent a few years in a Spanish-speaking country, does not contribute to closing the gap. These practices just give the appearance of closing the gap.

As a field that promotes and values quality outcomes and patient safety, we need to begin to develop our own standards for meeting the requirements of limited- and non-English speaking patients. We need to begin to measure our success and share our best practices. Although Executive Order 13166 mandates that hospitals have language assistance programs in place, it provides very few clues about how to do it, and what are acceptable standards.

We have an opportunity, as a field, to establish our own guidelines and quality standards that create voluntary accountability. Let’s not fail to take advantage of the opportunity to regulate ourselves. We all know what will happen if we don’t.
Nebraska health care organizations recently launched an ad campaign to increase awareness of the wide variety of available health care careers and improve minority representation throughout the state’s health care workforce. The campaign includes a poster titled, “The Changing Face of Health Care: Opportunities as Diverse as Our People,” which depicts a range of occupations and minority groups. More than 2,500 posters have been distributed to high school guidance counselors to display in their offices and at career fairs. In addition, several hospitals have featured the poster on their community billboards.

According to Molly Nance, senior director of communication and education at the Nebraska Hospital Association (NHA), the organizers, who meet regularly to discuss health care workforce issues, undertook the campaign after realizing that the make-up of the state’s workforce was not keeping pace with the state’s diversifying population. Nebraska’s population has rapidly changed over the past decade, with the Latino population in particular experiencing large growth. The same trend also is being seen at the national level. According to the 2004 report, Missing Persons: Minorities in the Health Professions, African Americans, Latinos and Native Americans account for more than a quarter of the U.S. population, but only 9 percent of nurses, 6 percent of doctors and 5 percent of dentists.

The poster, which also is available in Spanish, features 12 Nebraskans selected from more than 60 applicants. Each applicant was asked to describe why they selected a career in health care and what they found most rewarding about their jobs. The featured finalists represent a variety of health care occupations, but a common theme emerged in their applications: all 12 said they “enjoy the challenge, technical skills and personal caring” inherent in health care delivery, and all said they want to make culturally competent care more readily available to state residents.

While it was important that the finalists represent multiple ethnic groups, it was equally important that they highlight the wide range of available health care careers. “We really wanted to combat and overcome some stereotypes people have about health care,” Nance said, noting that many people aren’t aware of the variety of occupations available beyond traditional bedside nursing. To drive the point home, the individuals featured in the poster include not only nurses and physicians, but pharmacy technicians, respiratory therapists, public health educators and unit secretaries, among others.

So far, the response to the campaign has been positive and the sponsors are looking for ways to do more. “We’ve really gained a greater understanding of the power of collaboration,” Nance said, adding that all of the sponsoring organizations share the common goal of increasing the number of students interested in health care careers.

In addition to the NHA, the other sponsoring organizations are: Nebraska Area Health Education Centers; Nebraska Center for Nursing; Nebraska Health and Human Services, Regulation and Licensure, The Office of Minority Health; Nebraska Health Care Association; Nebraska Medical Association; Nebraska Minority Public Health Association; Nebraska Pharmacists Association; and University of Nebraska Medical Center Rural Health Education Network. Additional information is available at www.hhss.ne.gov/minorityhealth.
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(VHA) is another health system that offers fellowships for mid-careerists to hone their leadership skills through its Executive Career Field Candidate Development Program. The two-year program seeks to develop participants’ leadership skills based on the VHA’s personal development model. Candidates are trained in personal mastery, systems thinking, organizational stewardship, creative thinking, technical skills, customer service, flexibility and interpersonal effectiveness. They also are paired with a mentor, a senior-level executive responsible for helping the candidate “seek out the right experiences over the program that will really help to round them out, as well as to provide that traditional mentoring relationship and provide guidance and contact,” according to Lisa Red, a VHA program specialist closely involved in the program.

Since the program’s inception in June 2002, 182 candidates have graduated, and 31 percent have been selected for executive positions. While the program is not specifically targeted at minorities, over one-fifth of program participants are people of color.

Rosalyn Cole, the associate director for administration at Fargo VA Medical Center in Fargo, ND, went through the program in 2003 with the goal of becoming an associate director. At the time, she had nine years of health care management experience under her belt and was chief, technology division, at the VHA’s national radiology program office, where her duties included managing the administrative operations, setting policies and procedures and writing handbooks for 154 facilities.

After being accepted into the program, Cole was paired with Richard Baltz, director of the Jackson VA Medical Center, who had previously served as an associate director. “This program gave me the opportunity to ask deep questions of leaders in VHA on operations as an executive,” Cole recalled. “You are able to talk to senior leaders about leadership and about the roads to success.”

She focused on strengthening her skills based on the VHA’s Executive Career Field Development Program. “The program gives you the ability for each person to identify what you need to work on based on those eight core competencies to make you a better leader as far as your technical skills,” Cole explained.

The program gave Cole skills necessary for her current position as the associate director for administration at the Fargo VA Medical Center, which she has held since May 2005. She is responsible for all administrative operations of the 59-bed hospital and 50-bed transitional care unit facility, as well as eight community-based outpatient clinics. In addition, she actively has promoted diversity by establishing a diversity council at the Fargo VA Medical Center and hiring several qualified women and minority managers, improving the hospital’s diversity by 24 percent in fiscal year 2006.

The diversity council “recognizes the value of diversity management at this station,” Cole said. “We want to celebrate that and make people aware that diversity makes our team better and accomplishes our goal of caring for veterans.” Cole also has served on the Under Secretary for Health Diversity Advisory Board, which seeks to improve workforce diversity throughout the VHA, for five years.

For more information on CHI’s fellowship program, please visit www.catholichealthinit.org and click on “Creating Work Communities of Choice.” Additional information on the VHA’s diversity initiatives can be found at www1.va.gov/diversity/.

Leadership Competencies and Advancement Disparities: A Logical Means to an Important End

BY RUPERT M. EVANS, MPA, DHA, FACHE
DOMINIC UBAAMADU, FACHE

Advancement Disparities among Health Care Administrators

The United States is becoming increasingly diverse. In 1900, one in eight Americans was non-white; today, that number is one in four. By 2050, it will be one in three (IOM, 2004). The health care industry needs nurses and other health care providers, but it also needs to reflect the diversity of the population, who, in one point or another, become patients. Therefore, health care needs to employ caregivers and leaders who represent diverse backgrounds.

Health care managers and executives who are non-white are in the same situation when it comes to climbing the organizational ladder. In 1992, the American College of Health Care Executives (ACHE) and the National Association of Health Services Executives (NAHSE) conducted a study that compared the career attainment of Caucasian and African-American health care executives. The study found that among individuals with similar training and experience, African Americans were in lower-level positions, made less money, and had lower levels of job sat-
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isfaction. The results of this study made way for the creation of the Institute for Diversity in Health Management (IFD), the only organization in the industry committed exclusively to promoting managerial diversity within the health care field (ACHE, 2003). In 1996, ACHE, NAHSE and IFD conducted a follow-up survey using many of the items included in the first survey. This second survey, completed in 2003, revealed that 23 percent of the U.S. hospital workforce was made up of African Americans and Hispanics. Unfortunately, less than 2 percent of minority groups held the positions of president, chief executive officer and chief operating officer (A Survey Comparing the Career Attainments of Minority and White Healthcare Executives, 1992, 1997 and 2003, American College of Healthcare Executives).

Following is a summary of the most important findings of the second study:

More white administrators than minority administrators worked in hospital settings.

White female administrators earned more than female minority administrators. When controlling for education and experience, compensation earned by white women remained higher than the compensation for males and females of minority groups.

White male administrators earned more than male minority administrators. When controlling for experience and education, the total compensation of male African-American and Hispanic administrators was approximately equal to that of their white counterparts.

Minority administrators expressed lower levels of job satisfaction than did white administrators. The items with which low satisfaction was reported included the following:

Pay and fringe benefits were not proportionate to the minority administrators’ contribution to their organization.

The degree of respect and fair treatment that minority administrators received from their leaders was inadequate.

The sanctions and treatment that minority administrators faced when they made a mistake were more severe than their action called for.

Fewer minority administrators than white administrators expressed that their organization had great personal meaning to them.

More minority administrators than white administrators stated that they experienced racial/ethnic discriminatory acts in the past five years, such as not being hired or being evaluated with inappropriate standards.

Only about 15 percent of female minority administrators aspired to be chief executive officers. In contrast, more white male administrators had such aspirations than male minority administrators.

The majority of minority administrators endorse efforts to increase the percentage of racial/ethnic minorities in senior health care management positions. Nearly half of their white counterparts were neutral or opposed to such efforts.

Recommendations to address the disparities found between the white and minority groups are being developed. A third race/ethnic survey is expected to be conducted in 2007.

Addressing the Problem
Serious thought is being given to addressing the issue of underrepresentation of racial and ethnically diverse individuals in senior leadership position in the field of health care management. Major stakeholder organizations like the ACHE, NASHE and IFD have worked to support students and young careerist through programs such as the IFD’s and NAHSE’s Summer Enrichment Programs, as well as the NAHSE’s Everett Fox Student Case Competition and the Student Career Development Forums. Many health care organizations have also responded to the need of the young careerist through the development of a variety of internships, fellowships and residencies in partnership with many university programs in health care and health systems management. The aforementioned programs have worked well in developing a healthy pipeline of underrepresented minorities (URMs) moving into the health care management field. The same stakeholder organizations have developed programs and services, which address the needs of senior executives through programs like the NAHSE CEO/Senior Executive Invitational Conference and the ACHE CEO Forum.

The groups that remain unaddressed are those middle-level managers who might need assistance and/or mentoring to ready them to finally assume senior level positions in the field. How does the health care management field insure that this group in the middle gain the necessary competencies related to the higher-level activities in health care administration today? A significant amount of work is being done around modeling competencies for health care management. Organization such as the National Center for Healthcare Leadership and the Healthcare Leadership Alliance have developed models which are driving the discussion around what should a health care executive be able to do at different points in his or her career. In accordance with Dr. Andrew Garman, Associate Chair, Department of Health Systems Management, Rush University, Chicago, there are seven recent health administration competency models all developed between 2002 and 2006, yet there are still only a few organizations which have developed formal program design for the mid-careerist.

Two best practice organizations have emerged as leaders in addressing the URM mid-careerists and their needs. The first is HCA, headquartered in Nashville TN. As the largest private operator of health care facilities in the world, it currently operates 191 hospitals and 82 outpatient surgery centers employing greater than 180,000 people worldwide. HCA created a COO Development Program as the perfect way to launch a mid-careerist into an effective senior hospital administrator.

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Assigned to a hospital as an Associate Administrator, a mentor – usually the CEO – guides the individual’s development as a superior health care leader. They are assigned to departments and their development is supported by periodic projects and seminars offered at the corporate offices. When ready, they are moved into a COO position and, ultimately, assume responsibility for an HCA hospital as CEO. We have seen some of the alumni of this program in action and are heartened by their progress and accomplishments.

Catholic Health Initiatives (CHI) is another leader in this area. CHI is one of the largest faith-based health care systems in the country. They operate in 19 states, and serve diverse communities in size, ethnicity, age, religious traditions and socio-economic levels. Catholic Health Initiatives’ middle management initiative – Executive Diversity Fellowship Program – is designed to attract and develop female, racial and ethnic minority candidates for leadership positions in health care and within CHI. Like HCA, this program is designed to give the young executives the tools and competencies necessary to move into senior leadership. Several of CHI’s market-based organizations are today benefiting from the energies and talents of health care leaders who recently completed this program.

These innovative programs are examples of what individual organizations can do to make a difference. Think of the possibilities if we had national programs which could help our health care system move toward significant change – eventually eliminating the need to survey and measure advancement disparities. We encourage health care organizations to join the efforts already made by IFD and continue to support their initiatives to partner with NAHSE and ACHE in developing new strategies to level the playing field for URM mid-careerist seeking to advance into senior level executives ranks.

Dr. Rupert Evans and Dominic Uba-madu are Healthcare Executive Search Consultants with the Desir Group. Executive Search with offices in Atlanta, Tampa and Chicago. Specializing in diversity search, Desir Group members have interest in, and are fully engaged with individuals and organizations addressing the issues of representation and advancement of minority and women administrators in the health care field. Dr. Evans can be reached at revans@desirgroup.com and Mr. Uba-madu can be reached at dubamadu@desirgroup.com.