

LEARNING THROUGH DIVERSITY: CREATING A VIRTUOUS CYCLE OF HEALTH EQUITY IN HEALTH CARE ORGANIZATIONS

Jessica H. Williams, Geoffrey A. Silvera
and Christy Harris Lemak

ABSTRACT

In the US, a growing number of organizations and industries are seeking to affirm their commitment to and efforts around diversity, equity, and inclusion (DEI) as recent events have increased attention to social inequities. As health care organizations are considering new ways to incorporate DEI initiatives within their workforce, the anticipated result of these efforts is a reduction in health inequities that have plagued our country for centuries. Unfortunately, there are few frameworks to guide these efforts because few successfully link organizational DEI initiatives with health equity outcomes. The purpose of this chapter is to review existing scholarship and evidence using an organizational lens to examine how health care organizations can advance DEI initiatives in the pursuit of reducing or eliminating health inequities. First, this chapter defines important terms of DEI and health equity in health care. Next, we describe the methods for our narrative review. We propose a model for understanding health care organizational activity and its impact on health inequities based in organizational learning that includes four interrelated parts: intention, action, outcomes, and learning. We summarize the existing scholarship in each of these areas and provide recommendations for enhancing future research. Across the body of knowledge in these areas, disciplinary and

Responding to The Grand Challenges In Health Care Via Organizational Innovation
Advances in Health Care Management, Volume 21, 167–189



Open Access with copyright assigned to respective chapter authors. Published by Emerald Publishing Limited. These works are published under the Creative Commons Attribution (CC BY 4.0) licence. Anyone may reproduce, distribute, translate and create derivative works of these works (for both commercial and non-commercial purposes), subject to full attribution to the original publication and authors. The full terms of this licence may be seen at <http://creativecommons.org/licences/by/4.0/legalcode>.

ISSN: 1474-8231/doi:[10.1108/S1474-823120220000021009](https://doi.org/10.1108/S1474-823120220000021009)

other silos may be the biggest barrier to knowledge creation and knowledge transfer. Moving forward, scholars and practitioners should seek to collaborate further in their respective efforts to achieve health equity by creating formalized initiatives with linkages between practice and research communities.

Keywords: Diversity; equity; inclusion; organizational learning; health equity; cultural competency

INTRODUCTION

US organizations are experiencing increased pressure to address historical and ongoing inequities by race/ethnicity and gender. Part of this pressure is due to rapidly changing demographics across the cultural landscape of America; it is anticipated that by 2060 current minority populations will be the majority in the US (US Census Bureau, 2018). Much of the immediacy in efforts to diversify organizations, however, came following the murder of George Floyd on May 25, 2020, amid the worst global pandemic in over 100 years. In response, people of all races, generations, and backgrounds publicly demonstrated all over the world in *the summer of racial reckoning* (Chang, Martin, & Marrapodi, 2020). Noting the significant impact that these events were having on organizational stakeholders, leaders across industries began to respond, seeking to address the organizational commitment to and efforts surrounding diversity, equity, and inclusion (DEI) despite the formidable challenges in doing so.

Most organizations are seeking to address DEI through intense focus on internal organizational practices, such as equitable hiring, fairness in compensation and promotion, and employee DEI awareness and education programs. Some firms also focused externally, providing public support of social justice and progress. For health care organizations, in particular, a concurrent call to action emerged as reports of race-based disparities in health care outcomes throughout the global COVID-19 pandemic emerged (Evelyn, 2020). The wide publicization of the disparate outcomes from COVID-19 reaffirmed the preceding and copious scholarly exploration of health care disparities in US health and public health systems, as well as the insufficient progress made in achieving equitable health outcomes. Research in this area has included a wide range of foci, including examinations of racial disparities in treatment access, care and outcomes, specific organizational practices designed to improve representation and inclusive cultures, workforce trends, environmental influences, and organizational collaborations across the care and public health continuum. While the focus has centered mainly on racial inequities, various sources of diversity have also been explored including gender, sexual orientation, ethnicity, age, and accessibility. DEI is a rapidly evolving field with influences from sociology, psychology, anthropology, public health, policy, health professions, education, and business. The purpose of this chapter is to review existing literature with an “organizational lens” to investigate how organizational DEI efforts could influence differences in health equity.

KEY TERMS AND DEFINITIONS

Health care organizations have endeavored to implement DEI initiatives in order to build a more diverse workforce, ensure equity among staff members and patients, and to cultivate working environments in which all employees feel included – all with an ultimate goal of achieving health equity. In the developing landscape of DEI, novel terminology continues to emerge. Recently, the importance of the pursuit of belongingness and social and racial justice have been emphasized as key drivers for DEI initiatives (Carter, 2020). Additional important terms such as racism, antiracism, authenticity, dignity, peace, intersectionality, sexualization, misgendering, ableism, and many others exist beyond the scope of this review. We begin by establishing and defining key terms that were the foundation for this review: diversity, inclusion, and equity. As shown in Table 1, definitions of key terms from general sources and from public service organizations – the US Department of Housing and Urban Development (HUD) and the US Centers for Disease Prevention and Control (CDC) – present important nuance around these key terms.

Table 1. Key Terms and Definitions Related to Diversity, Inclusion, and Equity.

Key Terms	Definitions
Diversity	Merriam-Webster The condition of having or being composed of differing elements, especially the inclusion of people of different races, culture, etc. in a group or organization (Merriam-Webster, n.d.-a) HUD Workplace diversity encompasses the range of similarities and differences that each individual brings to the workplace, including but not limited to national origin, language, race, color, disability, ethnicity, gender, age, religion, sexual orientation, gender identity, socioeconomic status, veteran status, and family structures (HUD, n.d.) CDC An appreciation and respect for the many differences and similarities in the workplace including varied perspectives, approaches, and competencies of coworkers and populations served (CDC, n.d.-a)
Inclusion	Merriam-Webster The act or practice of including and accommodating people who have historically been excluded because of race, gender, sexuality, or ability (Merriam-Webster, n.d.-b). HUD For organizations, an important aspect of inclusion is that it be reflected in the culture, practices, and relationships in order to support a diverse workforce; inclusion is about focusing on the needs of every individual, ensuring that the right conditions are in place for each individual to achieve his, her, or their full potential (HUD, n.d.). CDC A set of behaviors that encourages employees to feel valued for their unique qualities and to experience a sense of belonging; a set of behaviors that promote collaboration within a diverse group (CDC, n.d.-a).
Equity	Merriam-Webster Fairness or justice in the way people are treated (Merriam-Webster, n.d.-c).

Note: HUD is the U.S. Department of Housing and Urban Development; CDC is the Centers for Disease Control and Prevention.

Human resource management literature offers the most directly useful definitions for health care organizations. As diversity can be defined as “a successful community in which individuals of different race, ethnicity, religious beliefs, socioeconomic status, language, geographical origin, gender and/or sexual orientation bring their different knowledge, background, experience, and interest for the benefit of the whole community” (Santiana, 2017). Diversity in health care organizations refers to the composition of the workforce involved in health care delivery, and whether these individuals adequately reflect the communities or patients they serve. The impetus behind creating a more diverse health care workforce is based on evidence that a more racially, ethnically, and linguistically diverse health care workforce is associated with better access to care and better quality of care for disadvantaged populations (Gomez & Bernet, 2019). In addition, a recent review of workforce diversity in human service organizations found that diversity is associated with enhanced creativity and innovation, improved workplace commitment, and increased retention (Mor Barak et al., 2016). There is considerable concern, however, regarding the scarcity of diversity in health care providers, executive leaders, and governance (ACHE, 2008; Dotson & Nuru-Jeter, 2012; Mitchell & Lassiter, 2006; Silvera & Clark, 2021; Smith, Nsiah-Kumi, Jones, & Pamies, 2009; Sullivan, 2004).

Inclusion in the health care workforce refers to achieving a work environment whereby all individuals are treated fairly and respectfully, have equal access to opportunities and resources, and are able to contribute fully to the success of the organization (SHRM, 2020). In order to support a diverse workforce within organizations, building an inclusive environment within an organization requires inclusive actions that shift attitudes, assumptions, and behaviors (Francis, Sampson, & Evans, 2021). Equity can be conceived as fairness in outcomes of any type, from hiring and compensation, to access to cancer treatment or equitable resources availability for prevention, treatment, and recovery. For health care organizations, there is a dual need to address DEI in the health care workforce, as well as make sure that the diversity of patients is appreciated and accommodated. This results in a need for leaders to be aware of issues in career advancement for employees from marginalized populations, as well address their organization’s role in meeting the newly named “quintuple aim of health care quality,” health equity (Itchhaporia, 2021; Nundy, Cooper, & Mate, 2022).

Achieving health equity is the ultimate goal of most DEI initiatives in health care. Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances” (CDC, n.d.-b). Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment (CDC, n.d.-b). Measures of health equity may be categorized as population-level indicators or organizational outcomes. The pursuit of health equity presents a unique challenge for the health sector as it demands that health care organizations simultaneously pursue two important sets of outcomes.

METHOD

We conducted a narrative review of literature related to management levers of implementing DEI in order to develop a framework for linking DEI initiatives to health outcomes and/or health equity. To begin, we reviewed electronic databases, diversity organization websites, and online management-related publications, including Pubmed, Google Scholar, Harvard Business Review, the Institute for Diversity, and the National Center for Healthcare Leadership. The review included peer-reviewed publications in management journals, theoretical and opinion articles, frameworks, and systematics reviews. The review was conducted between December 2021 and March 2022 and included search terms “diversity in organizations” AND “chief diversity officer healthcare medicine” AND “inclusion in healthcare workforce” AND “diversity in the workplace” AND “diversity in business management” AND “diversity, equity, inclusion” AND “cultural competence” AND “gender in medicine” AND “population health and DEI.” Abstracts were evaluated and coded into categories of population health, health equity and disparities, chief diversity office and leadership levers, gender in medicine, workforce, intentions, and cultural competence management levers. For abstracts that fit into the theme of the chapter, full papers were retrieved and were assessed for inclusion. Studies included in the narrative review met the following criteria: (1) published 2005 or later, (2) described pertinent management levers related to diversity, equity, and inclusion, and (3) were peer-reviewed publications in management journals, theoretical and opinion articles, frameworks, and systematics reviews. Due to the dearth of articles making a direct linkage between DEI and health outcomes and/or health equity, papers with a focus on cultural competency in health care were included because of its linkage to health outcomes and its alignment with principles of DEI.

ADVANCING DIVERSITY TO ACHIEVE HEALTH EQUITY

While many health care organizations strive toward organizational change that would ultimately result in more equitable health outcomes, few conceptual frameworks have been developed that directly link organizational DEI initiatives to health equity outcomes. Several have suggested that, for example, diversification of the health care workforce and health professions will result in improvement of health disparities (Mitchell & Lassiter, 2006; Williams et al., 2014) without providing a framework to explain how diversification might translate to improvement in health equity outcomes. We examine the current research and propose a framework to explain how the advancement of workforce diversity translates to achieving health equity.

Our proposed framework is inspired by the *learning and effectiveness paradigm* proposed by Thomas and Ely (1996) which argues that organizations can cultivate a learning orientation toward diversity which leverages employee experiences as members of particular identity groups to reconceive tasks, products, business processes, and organizational norms to enable increased organizational

effectiveness. This paradigm emphasizes that, for example, the goal of recruiting and retaining people from underrepresented groups is to tap into their identity-related knowledge and experiences, and that doing so enables teams to be more effective than either homogenous teams or diverse teams that do not learn from their members’ differences (Thomas & Ely, 1996). Most organizations do not assume a learning approach to diversity, and, instead, assume that by increasing the number of traditionally underrepresented members to the workforce, the organization will automatically produce organizational benefits (Thomas & Ely, 1996). Empirical findings have shown, however, that (1) increasing diversity does not, by itself, increase effectiveness; (2) what matters is how and whether organizations harness the diversity in their workforce to maximize learning; and (3) whether organizations are willing to reshape power structures as part of that effort (Thomas & Ely, 1996).

In Fig. 1, we depict a cyclical framework for achieving health equity through the advancement of diversity in health care organizations. In this framing, we suggest that cycles of DEI in health care organizations include four distinct stages: *intention*, *action*, *outcomes* (*organizational and community*), and *learning*. For explanatory purposes, intention can be conceived of as the first step in this process with action following and so forth, but in reality and in research these steps may or may not happen in sequence as presented. One advantage of a cyclical framework (as opposed to linear) is that it recognizes that achieving health equity is an ongoing and iterative process. Additionally, a cyclical framework reflects that organizations in pursuit of health equity are not moving toward a discernible target as an organization could never be maximally equitable, just as organizations could never be maximally efficient, economical, or

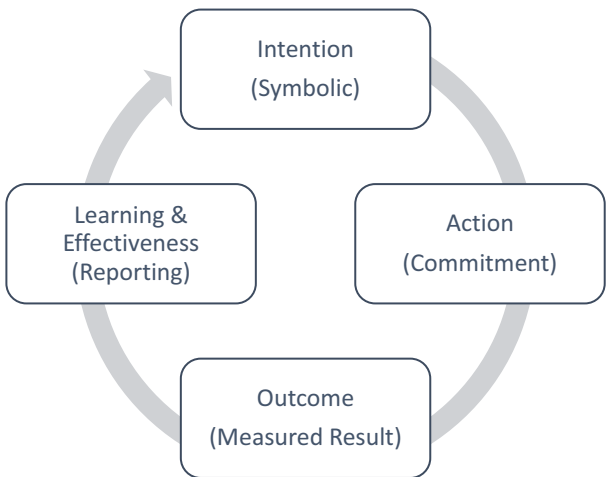


Fig. 1. The Cycle of Advancing Diversity to Achieve Health Equity in Health Care Organizations. Source: Adapted from the Learning and Effectiveness Paradigm (Thomas & Ely, 1996).

excellent. Health equity is not a destination, but a pursuit. As such, linear frameworks of health equity are incomplete in appreciating the experimental nature of this pursuit and its need for iteration and feedback throughout.

A key consideration of the *learning and effectiveness paradigm* (Thomas & Ely, 1996) is that alongside the virtuous cycle of learning, there also exist counter currents, or vicious cycles, of oppression. Oppressive systems such as racism, patriarchy, sexism are also cyclical in nature and work against the advancement of health equity. For example, structural racism, defined as the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice (Bailey et al., 2017) can be thought to be initiated by prejudice and bias which feed into the creation of racist policies, practices, and structures which drive stereotypes and discrimination leading to disparate outcomes which lead back to prejudice and bias. The cycles of oppressive systems are ubiquitous, insidious, and dangerous, and, for these reasons, the challenges to address them within organizations are formidable.

In the next section, we describe each stage of the virtuous cycle of health equity in health care organizations and summarize the scholarly contributions therein (or lack thereof). We recognize that some of the studies and activities could occur in multiple stages of the cycle. We also acknowledge that much of the work to date is either conceptual or applied to a single organization or setting.

INTENTION

Intention is a symbolic indicator of organizational interest in pursuing inclusion initiatives by key-decision-makers within the organization (C-suite leadership, hospital governing boards, and the like). This intention might be indicated in mission, vision, and value statements; press releases; and other signals. Health care leaders set the intention and, ideally, not only support diversity education for employees but also embrace the diversity of the communities the hospital serves (Grant, 2010). The literature in this area is categorized into two categories: *signaling* and *public commitments to diversity*.

Signaling. The primary way organizations can indicate their intentions to pursue equity is through the use of various signals. A recent study examined the use of what the scholars termed “diversity value signaling” in health care organizations (Cole, Haun, & Silvera, 2022). Diversity value signaling is an extension of signaling theory (Spence, 1978), which argues that organizations communicate to stakeholders through various symbolic “signals” of the organization’s values, goals, and expectations (Celani & Singh, 2011; Suazo, Martinez, & Sandoval, 2009). Diversity value signaling is defined as the use of inclusive language and terms in public organizational communication, such as mission statements [mission, vision, and values], job advertisements, press releases, media advertisements, and diversity statements, which may reflect a strategic intention to value diversity and inclusion (Cole et al., 2022). For example, scholars suggest

that organizations consider heavily how they represent the diversity of their workforce in marketing materials and websites (Celani & Singh, 2011).

An early study examining diversity value signaling in health care organizations found a positive relationship between signaling via nursing job advertisements and hospital performance measured through rankings (Cole et al., 2022). No study has yet explored whether signaling in advertisements diversifies the job applicants or if it is indicative of greater intensity of DEI within the health care organizations (Cole et al., 2022). It is important to also note that signals can vary in intensity and the context of the signaling is just as important to consider the magnitude of the signaling (Celani & Singh, 2011). For example, a commitment to diversity can be communicated to company employees via email or that same message can be relayed in a press release or on the company webpage. Further, variability in signal strength across contexts can perhaps be an indication of the strength in commitment to DEI and the goals therein.

Public Commitments to Diversity and Health Equity. In recent years, efforts to increase health system involvement and commitment to DEI have been developed by national and international organizations to aid health care organizations in their drives for organizational change. For example, the Institute for Healthcare Improvement (IHI) provides toolkits, videos, and other resources for health care organizations and systems (IHI, 2021). The American Hospital Association's Institute for Diversity and Health Equity established its “#123forEquity” Campaign in 2015 to accelerate progress on hospital and health system efforts to eliminate disparities. In this campaign, hospitals and systems were asked to take the pledge and commit to work on these issues, and extensive library of tools and resources were made available to organizations “focusing on practical, how-to solutions to help hospitals and health systems of all sizes to build more inclusive and equitable communities.” As of early 2022, almost 1,800 organizations have signed the pledge (AHA, 2022). No studies have assessed the degree to which public commitments have resulted in organizational DEI actions or improved health equity outcomes.

ACTION

Following intention is a definitive *action*, or series of activities directly germane to addressing DEI within the organization. *Action* includes commitment of time, capital, and other organizational resources with the specific purpose of improving diversity, reducing disparities, or improving health equity. The American Hospital Association's “Equity Roadmap” (AHA, 2021) highlights six domains for organizational action to improve equity and reduce disparities: (1) collection and use of data, (2) community collaboration for solutions, (3) culturally appropriate patient care, (4) diverse representation in executive leadership and governance, (5) equitable and inclusive organizational policies, and (6) systematic and shared accountability. For the most part, these actions are difficult to measure, as is the linkage to outcomes. Furthermore, studies have a tendency to include a variety of actions, making it difficult to connect outcomes to specific actions. We summarize

the literature in the following four categories of action: (1) culturally appropriate patient care, (2) diverse representation in executive leadership and governance, (3) equitable and inclusive workforce diversity, and (4) strategic partnerships for solutions.

Culturally appropriate patient care. Since the early 2000s, much of the focus on DEI in health care organizations has been under the umbrella of creating a culturally competent organization. This focus is based on the premise that culturally appropriate patient care will lead more equitable health outcomes. Cultural competency is described as a strategy for health care organizations to improve quality, lower cost, and attract customers (Weech-Maldonado, Al-Amin, Nishimi, & Salam, 2011). The most common strategies for cultural competence strategies include minority recruitment into health professions, interpreter and language-appropriate services (Aries, 2004), provide education on cross-cultural issues (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003), health promotion initiatives, workforce development and student education (McCalman, Jongen, & Bainbridge, 2017). Efforts to increase cultural competence are also promoted as a strategy to address health disparities in health and health care (Betancourt et al., 2003; Brach & Fraser, 2000; Nair & Adetayo, 2019; Weech-Maldonado et al., 2011). Theoretically, the lack of understanding of patient culture is attributed to the differences in treatment.

The motivation for implementing cultural competence in health care organizations varies by mission, goals, and sphere of influence (Betancourt, Green, Carrillo, & Park, 2005). Organizational cultural can either enhance or hinder commitment to cultural competency (Arndt & Bigelow, 2011). In order to manage a culturally diverse workforce, a leader must be motivated to develop the cultural competence to engage with them (Hunt, 2007), and an effective approach to building a culturally competent health care organization combines a focused and systemic approach to organizational change with interventions that encourage individual growth and development (Weech-Maldonado et al., 2018). Dreachslin, Weech-Maldonado, Gail, Epané, and Wainio (2017) proposed five competencies of strategic diversity management: (1) diversity leadership (2) strategic human resource management (3) organizational climate (4) diversity climate, and (5) patient cultural competence. Early studies note that hospitals should adopt diversity management practices, including marketing and service planning activities, in order to provide culturally appropriate care (Weech-Maldonado, Dreachslin, Dansky, De Souza, & Gatto, 2002), and that self-assessment and diversity training are key to workforce diversity management (Shaw-Taylor & Benesch, 1998). Recently, however, scholars have argued that greater attention should be focused on both cultural competence and racial and ethnic diversity in leaders at all levels, including medical students, residents, attendings, and management (Nair & Adetayo, 2019).

The extant literature supports the effectiveness of cultural competence training on several dimensions of individual and interprofessional effectiveness within the health care workforce. Cultural competence training improves knowledge, attitude, and skills among health professionals (Beach et al., 2005). Higher perceptions of organizational cultural competence results in a better teamwork climate

(Kumra et al., 2020). A comfortable work environment for employees of different racial and ethnic backgrounds is the strongest factor for organizational cultural competency (Allensworth-Davies et al., 2007). Cultural competence is also considered a critical aspect of providing quality care (Aries, 2004).

Cultural competence training may also positively impact health disparities. For instance, Dreachslin, Weech-Maldonado, and Dansky (2004) conceptualized a three-legged stool for initiatives to reduce racial and ethnic health disparities through cultural competence training. These include public policy (to ensure legal and regulatory authority to eliminate disparities in access to care), clinical practice (to ensure patient satisfaction through culturally competent care), and organizational behavior (to ensure that leadership, staff, and organizational culture represents and finds value in the communities they serve) (Dreachslin et al., 2004).

Culturally competent care has shown favorable results in many patient outcomes including: fewer reports of being treated with disrespect (Blewett, Hardeman, Hest, & Winkelman, 2019); higher quality of asthma care for children in managed Medicaid (Lieu et al., 2004); better safety culture in hospitals (Upadhyay, Stephenson, Weech-Maldonado, & Cochran, 2021); better HCAHPS scores for doctor communication, hospital rating, and hospital recommendation (Weech-Maldonado et al., 2012); and better diabetes outcomes (Zeh, Sandhu, Cannaby, & Sturt, 2012). Culturally competent hospitals also tend to be not for profit, serve a more diverse inpatient population, and located in more competitive and affluent markets (Weech-Maldonado et al., 2011). Studies have suggested greater attention to collaborations between researchers and practitioners in order to make a more direct link between culturally competent care and a reduction in health disparities (Dotson & Nuru-Jeter, 2012). It has also been recommended that research move toward a broader conceptualization of cultural competency by focusing on cultural safety (Curtis et al., 2019).

Despite efforts toward improving cultural competency in health care organizations, disparities still persist in outcomes for many marginalized groups. Income inequalities are barriers to accessing care for Hispanics and Blacks (Clark, Ommerborn, A Coull, Pham, & Haas, 2016). Older Hispanics, American Indians and Alaska natives with medicare experience disparities in getting care quickly, getting needed care, doctor communication, care coordination, and customer service (Martino et al., 2020, 2022). The COVID-19 pandemic highlighted a higher mortality rate from in Blacks (Krouse, 2020). In addition, Blacks, Hispanics, native Americans, and immigrants are most likely to experience health disparities overall by disease burden, health care, and health outcomes (Krouse, 2020). Moving forward, scholars recommend that instead of focusing on the elimination of health disparities, research should focus on achieving racial equity and dismantling structural racism (Lavizzo-Mourey, Besser, & Williams, 2021). Therefore, while culturally competent organizations have demonstrated improvements in some patient outcomes, cultural competence training alone is not sufficient to improve health equity outcomes.

Diverse representation in executive leadership and governance. Decision-makers within organizations drive intentions and actions. Specifically, a diverse

leadership team – including boards of directors – signals to key stakeholders that an organization is committed to inclusion and social justice (Broome & Krawiec, 2008). When leadership lacks diversity, organizational policies and norms may indicate devaluing the importance of diversity and inclusion (Simonsen & Shim, 2019). The leadership team, their intentions, and how they are leading the organization can be viewed in terms of racial/ethnic and gender representation on hospital boards and executives. Leadership diversity based on either gender, racial, or sexual identity is proposed as a driver for organizational performance on DEI and health equity. For example, early studies suggested that diversity at the highest level of health care organizations may be the most important driver for improving health outcomes. The underlying assumption is that diverse representation on boards and in leadership – including the addition of a “chief diversity officer” (CDO) – will lead to culture change, practices, and outcomes, yet few studies examine these relationships. Scholars have also highlighted challenges in empirically demonstrating the effect of diverse chief executives in US hospitals due to the general lack of diversity in the C-suite (with respect to gender and racial backgrounds) (Silvera & Clark, 2021).

Recently, the American Hospital Association surveyed hospitals about actions to improve health disparities and found that the impact of diverse leadership at all levels within hospitals has varying impact on organizational outcomes. Hospitals with more racially and ethnically diverse boards had higher scores in four categories of performance (leadership and strategic planning, workforce, data collection, and reducing disparities), suggesting that these hospitals pursued substantially more strategies in each of these domains. Conversely, hospitals with more racially and ethnically diverse C-suites only scored high in one domain (data collection) and hospitals with a higher percentage of women in executive positions had lower scores in all domains except data collection. Greater representation of racial and ethnic minorities in leadership positions was associated with greater commitment to diversity initiatives, while greater representation of white women in leadership is associated with fewer diversity initiatives (Herrin et al., 2018).

Many health care organizations are moving toward adding the role of CDO. Much of the literature on the role of CDOs has been within the context of higher education. In colleges and universities, CDOs are considered the face of diversity efforts (Williams & Wade-Golden, 2007), are change agents for DEI (Worthington et al., 2014); and provide strategic guidance for diversity planning and implementation (Leon, 2014). The role of CDOs is much less defined in health care organizations, and there is no empirical evidence to date of how a CDO operates within the context of a health care organization. The intent is that a CDO will serve as a change agent that will ultimately impact the organization by creating a more inclusive workforce that positively impacts health and health equity outcomes. There is little evidence of the impact of CDOs on improving health equity outcomes – likely due to the novelty of these positions and limited time for observable differences in outcomes.

Equitable and inclusive workforce diversity. Most initiatives around improving workforce diversity should focus on increasing the numerical representation of

historically excluded groups, empowering a diverse workforce to fully participate in organizational decision-making, and continuously communicating the business case and value of diversity for all employees and how it supports the organization's mission, vision, and values (Francis et al., 2021). Workforce diversity training may also focus on awareness building and attitude changes rather than behavior change (Curtis, Dreachslin, & Sinioris, 2007). Diversity training takes many forms, and there is quantitative evidence that diversity training improves affective-based (attitude, motivation), cognitive-based (verbal knowledge and strategies), and skill-based (behavior change) outcomes (Kalinowski et al., 2013). Regardless of the approach, it is important to acknowledge that individuals learning about diversity is not enough to guarantee a sensitivity to diversity at the organizational level (Celik, Abma, Klinge, & Widdershoven, 2012).

For this reason, Curtis et al. (2007) suggest that diversity training should take a systems-level approach, wherein DEI training is aligned with the health care organization's strategic goals for improved quality of care. Developing a diversity-sensitive organization requires senior leaders to openly commit to recruiting, retaining, developing, and supporting underrepresented candidates, educating and convincing others that this is a long-term strategy for the organization, and maintaining the focus on the process whereby it is easier to comply than to resist (Dreachslin, 2007). Although minority participation in hospital senior management is sensitive to local market factors (total population, proportion of minorities in the population, relative number of minorities with a bachelor's degree, and concentration of local hospital markets), these market factors have a small influence on minority participation in hospital senior management (Gaumer, Coulam, & Desilets, 2021). Therefore, organizations will need to be intentional in implementing initiatives that promote diversity – using strategies such as targeted recruitment and training programs (Dobbin, Schrage, & Kalev, 2015), as well as pipeline programs (Smith et al., 2009). Much of this intentionality must be modeled through organizational leadership. Leaders who can transcend their own racial identity to validate alternative realities and appreciate different perspectives moderate the potential negative effects of racial diversity on team communication processes and strengthen the positive aspects of diversity (Dreachslin, Hunt, & Sprainer, 2000).

Gender parity is frequently discussed in the context of workforce diversity. Women comprise the majority of entry-level jobs within health care organizations, yet women are underrepresented in the top echelons of health care leadership (Lantz, 2008; Silvera & Clark, 2021). Thus, the majority of decision-making power for organizational policies around gender equity and career advancement rests under the purview of men. Despite some advances in opportunities for women in leadership in recent years, COVID-19 may have exacerbated existing gender inequities in professional visibility, networking and collaboration as activities transitioned to virtual environments, resulting in new barriers to advancement for women (Woitowich, Jain, Arora, & Joffe, 2021). Even when controlling for educational attainment, age, and experience, salary disparities remain between women and men working in similar roles within health care organizations (Lantz, 2008). Unfortunately, health systems have not had a

productive track record in addressing gender parity and may reinforce traditional gender roles by neglecting gender inequalities in health (Hay et al., 2019). Women who work in health care tend to have less authority than men and often experience abuse or are devalued (Hay et al., 2019). Of note, evidence suggests that gender parity is not sufficient to achieve gender equality (Hay et al., 2019). A multisectorial approach is needed to promote gender equality that includes national government, global health institutions, civil society organizations, academic settings, and the corporate setting in order to achieve health outcomes. Activities may include reforming the workplace to be more conducive to gender equity, eliminate gender bias in research, fund social movements, and strengthen accountability (Gupta et al., 2019). As with racial diversity, disparities in gender diversity can be changed with intentionality through organizational leadership, commitment, and accountability (Mousa et al., 2021). The alternative to greater representation of women in leadership is lower workplace satisfaction due to male culture, lack of sponsorship, lack of mentoring, and queen bee syndrome (Hefner et al., 2021).

Strategic partnerships for solutions. Knowledge seeking is the primary action indicating progress toward inclusion. One example of organizational action is joining a coalition of organizations that are creating knowledge-sharing networks, such as the National Center for Healthcare Leadership, the Institute for Diversity, or Institute for Healthcare Improvement. Another example is the development of an “anchor institution.” Anchor institutions are “place-based, mission-driven entities such as hospitals, universities and government agencies that leverage their economic power alongside their human and intellectual resources to improve the long-term health and social welfare of their communities” (Pinderhughes et al., 2019). At least 65 leading health care systems are working together to improve health equity under this framework as part of the Healthcare Anchor Network that began in 2016 and provides a toolkit designed to provide health care leaders information to move toward community health and well-being.

OUTCOMES

Outcomes are measurable performance metrics that can indicate the degree to which the activities undergone in the *action* stage of the cycle were able to augment DEI relative to the specific target area. *Outcomes* might include organizational outcomes or community-oriented disparities and equity indicators. Most of the research in this area focuses on demographic and financial indicators, but more work is needed to measure and understand how health care organizations are instrumental in community health improvement (and disparities are reduced). Health care organizations have a dual challenge as DEI initiatives are also thought to contribute to the challenge of achieving health equity. While a need to address structural racism in order to achieve health equity has been noted (Hardeman, Hardeman-Jones, & Medina, 2021), the link between DEI initiatives in health care organizations and health equity outcomes has not yet been

established in the literature. No studies have been able to provide evidence of the link between DEI initiatives within the health care organizations and the improvement of health equity in communities. This may be due to the notion that, despite often being conflated with each other, the challenges of DEI in health care and the challenges of advancing health equity are distinct challenges.

Addressing structural racism in health care organizations may offer a concrete, feasible, and promising approach to the advancement of health equity and toward improving population health (Bailey et al., 2017), but there is also limited evidence to suggest that health care organizations have the capacity to contribute to health equity (Edelman, Taylor, Ovseiko, & Topp, 2017). As Crews et al. (2021) notes, this may be because DEI and health equity are disjointed, and need to be brought together, but there are no best practices. This disconnection helps to explain how health disparities have continued to persist, and in some instances worsen, despite the majority of health care organizations reporting that they are working to address health disparities (Vizient, 2021). Perhaps by applying a learning conceptual cycle that links DEI initiatives to health equity outcomes these challenges can be confronted in concert.

LEARNING AND EFFECTIVENESS

Outcomes lead to knowledge generation for the organization in the form of organizational *learning*. Learning is what occurs when organizational actors evaluate the efficacy of DEI interventions and outcomes to determine the effectiveness of the intervention. Knowledge generated through this evaluation process is then used to sharpen leadership team intentions, and the cycle continues. A *learning* orientation to DEI is noted as quite difficult, and this may account for the general lack of empirical studies in this area. The literature, however, provides recommendations of tasks that can be done to avoid the most common pitfalls in failing to learn from DEI initiatives.

The first task is to build and cultivate trust within the organization around these issues (Thomas & Ely, 1996). The organization must set a tone for honest discourse which requires that individuals be made comfortable with their own vulnerability and others' (Thomas & Ely, 1996). Another task is to address discrimination and subordination and actively work against them (Thomas & Ely, 1996). Leaders can start to do this by first understanding how systems of privilege and oppression (racism, sexism, ethnocentrism, classism, heterosexism) operate in the wider culture, but for the organization to benefit from leader's education, it must be followed by collective investigation across the organization into how these systems are sustained within the organization (Thomas & Ely, 1996).

One aspect that makes the "vicious" cycles of oppression particularly insidious is that they do not need intention to initiate the cycles. In other words, these cycles operate without the need for directed action and will operate continuously if left unchecked. Health care is no exception as structural racism has been identified as a driver of the quintuple aim of health care delivery, health equity

(Itchhaporia, 2021; Nundy et al., 2022). Structural racism was also shown to operate as a fundamental cause of racial/ethnic inequalities in COVID-19 among adults, for example, because of its influence on risk of exposure, the weathering process, and health care access and quality (Garcia, Homan, Garcia, & Brown, 2020). There is a need, therefore, for organizational leaders to question to what degree organizations are operating as sites of oppression (reinforcing oppressive systems) or liberation (mitigating oppressive systems), and a demand for organizations to engage in initiatives to “unlearn” the individual and organizational drivers that perpetuate these vicious systems while simultaneously learning through DEI initiatives. Success in these efforts requires a well-articulated organizational mission to motivate change combined with a process of continuous reflection, experimentation, consciousness-raising, and sustained iterative action to ensure changes are impactful (Thomas & Ely, 1996).

Another challenge in the cultivation of the learning and effectiveness paradigm (Thomas & Ely, 1996) within health care organizations is that DEI initiatives are often siloed despite often addressing similar challenges with different target populations. One example is the training for cultural competency based on language preferences between patient and providers which encourages providers to make translation and interpretation services available for the patients. This protocol could also be used to aid patients who have hearing loss or other communication disorders despite speaking in the same language. One strategy for diminishing the siloed structures that often emerge in DEI initiatives is for organizations to seek to be inclusive in their diversity management approaches. Specifically, the literature suggests the creation of incorporating structures among diversity management initiatives to ensure contingencies and continuity across varied DEI initiatives (Fisk, Silvera, & Haun, 2019). This involves the dedication of resources to permit continuous evaluation of programs and the ability to deliver culturally competent goods and services (Fisk et al., 2019). Doing so may enable organizations to embrace a variety of styles and voices as leaders must actively seek to understand how organizational norms may or may not be serving their goals as norms may implicitly discourage certain behavioral styles or silence certain voices (Thomas & Ely, 1996). The final recommended task is for organizations to encourage open discussions about how groups from underrepresented identities contribute and shape the experience of employees within the organization and society (Thomas & Ely, 1996).

DISCUSSION AND RECOMMENDATIONS

Despite the increased focus on DEI and how health care organizations can influence health equity, there is little empirical evidence linking these important concepts. This summative review of the literature reveals that most of the work in this area relies upon the belief that intentions will lead to actions and actions will lead to outcomes in organizations and communities. With the exception of studies focused on outcomes linked to cultural competence, this review failed to identify any evidence linking DEI actions or intentions to health equity. In this discussion,

we describe why we believe this is so and provide recommendations for future exploration.

Within the growing scholarly work in health care DEI, some foci have developed, such as in the areas of cultural competency training, implicit bias training, workforce diversity, and leadership diversity. Within our framework, each of these would be considered as actions that will lead to organizational outcomes. All too often, studies are specific to a single organization (or unit). Other studies make general conclusions without adequately considering context and other exogenous factors, thereby limiting generalizability and reducing opportunities for future study and “spread” throughout the field. For example, as scholars begin to study the role and influence of health care CDOs, there remain questions on the roles and resources provided to CDOs across hospitals and that a relatively low percentage of hospitals and health systems have added the CDO role to date (Hogan, Hefner, Stephens, & Lemak, 2022).

The role of hospital and health system leadership in advancing diversity, equity, and inclusion cannot be overstated. Conceptual models and suggestions in this area almost universally identify leadership commitment and behaviors of senior leaders to be an essential. The field of health care leadership research is growing, and some scholars have begun to examine this from the perspectives of identifying and defining DEI-related leadership competencies (Edwards, Till, & McKimm, 2018; Weech et al., 2018) and evaluating organizational interventions (Herrin et al., 2018; Mousa et al., 2021). Some of this work is done in various clinical disciplines (e.g., radiation oncology, surgery) or national health systems (e.g., Great Britain’s NHS, Canada’s system). There is an opportunity for greater synthesis and integration of models and findings in order to accelerate progress.

An emerging concern in the area of health equity scholarship is *health equity tourism* (Lett et al., 2022), wherein scholars who are not invested in nor are experts in health equity concepts engage in disparities-related research without understanding how inequalities might be driving these disparities. One cited example is the explanation for disparities in COVID-19 outcomes based on race being related to genetic differences across races as opposed to social inequities despite a robust literature that has established that social inequities drive differences in disease burden and that race is not a good indicator of genetic grouping (Lett et al., 2022).

Academia itself is developing a body of knowledge in this area, which can help drive intentions toward action in our proposed framework. In some academic settings, it is perceived as more important to develop a new conceptual model than to apply or test an existing one. In general, quantitative studies are still more likely to obtain external funding and to be published over qualitative or mixed-methods approaches. Further, some have suggested in recent months that doing “race” or “DEI” scholarship is risky for academics in the current political environment. Leaders in health care management and health services research arenas could advocate for the benefits and importance of more focused, collaborative, and applied work in this area, despite institutional and environmental pressures to the contrary. We suggest that we become more aware of our own viscous cycles in academia.

Recommendations for enhancing future research. Within the framework of a virtuous cycle of organizational intention, action, outcomes, and learning, we suggest the following recommendations for improving health care organizational scholarship. In this area, like many others, the field of practice may be moving faster than rigorous theoretical and empirical research. It will be important for scholars to work with practitioners to establish a reliable and valid body of knowledge to support, and even accelerate, movement toward improving health equity. More formal and consistent linkages between the practice and research communities are essential.

Siloes across professions and disciplines may present the biggest barriers to knowledge creation and dissemination regarding health care organizations' DEI efforts and health equity outcomes. This is true both in practice and within academia, as DEI (and "racism") scholars are developing theory and doing applied research in the distinct disciplines of education, business, policy, management, public administration, medicine, and biology to name a few. This is an area where cross-disciplinary and interdisciplinary research opportunities abound. Disentangling the social and other determinants of health is multifaceted and most scholarship occurs in one silo only. Another influential silo includes work orchestrated by consulting and advocacy organizations in the "gray literature." Health care organizational leaders (and scholars) have come to rely on reports and recommendations from organizations like the Institute for Health care Improvement, the Institute for Diversity/the American Hospital Association, the Kellogg Foundation, the Anchor Institution Network, McKinsey and others. These are indicators of substantial attention to health equity and disparities, but they have not coalesced into a consistent body of knowledge.

How might scholars across different disciplines more consistently and effectively share their findings with leaders in the field? One mechanism could be through existing repositories such as the AHA/IFD HEAL initiative. Another example is the National Center for Healthcare Leadership's monthly e-newsletter summarizing recent studies in their key focus areas (including DEI) to leaders across the country. Social media has become influential in some subsets of DEI work, in particular among women in medicine (e.g., #WomenInMedicine; #ilooklikeasurgeon), nursing (e.g., #NursingWhileBlack) and among various diversity scholars. There are opportunities to be more strategic about how to use social media to connect academics and practitioners in this area.

We may need new methodological approaches in order to do better health care DEI scholarship to appropriately address levels of analysis, embedded organizations and systems, and the like. We also recommend that health care DEI scholars be more precise in language, expectations, and research aims. Many papers reviewed here began with the ultimate goal of improving health equity (population level), but none made the linkage between organizational intention or action to community-level health equity measures. Assumptions are made through this virtuous cycle, but there is almost no science to support the final link. That does not mean, however, that we should stop doing the work we can. More research is needed to help us understand whether the sustainability of addressing DEI in the health care workforce depends on making its link to health outcomes

clear. If organizations fail to see improvements in patient and community health outcomes, we may expect that DEI (and potentially the CDO role) will no longer be a priority.

We suggest that future studies consider whether community differences in demographic characteristics (e.g., racial and ethnic diversity) may be associated with variation in health care DEI organizations' intention and actions. For example, are DEI efforts further along in more diverse and urban markets? In the Deep South? How do learning and activity in local communities inform the work being done in health care organizations? How does this work move forward in communities with minimal racial diversity? There may be opportunities to consider how Minneapolis-St. Paul has moved on intention/action/outcomes after the events of 2020. How do political environments influence health care organizational diversity efforts, for example, in Texas, Florida, and other "Red" states given recent proposed legislation regarding "Critical Race Theory"? Another potential study could examine differences in COVID-19 treatment and outcomes in areas between hospital and communities with fewer or more CDOs in place before the pandemic.

Likewise, there may be research questions linking prior work on hospital and health system organizational performance to organizational diversity and community health equity indicators. For example, while there is some evidence linking the gender of hospital leadership to patient experience scores (Galstian et al., 2018; Silvera & Clark, 2021), as noted previously, there is an opportunity to go further, examining diversity indicators at the hospital and health system level to patient outcomes by race and gender and to further consider the relationships between community socioeconomic indicators and hospital performance. Various consultants and advocacy groups suggest the competitive advantage of leadership representation and inclusive cultures, and yet we found no studies empirically exploring these relationships. The ongoing development of publicly available rankings of health equity such as the US News Reports adding a Health Equity Index to their hospital ranking system (SOURCE) are encouraging in this regard. This work must continue even as we see variation across the industry with regard to uptake of DEI within organizations. Only a handful of institutions are affiliated with organizations such as the Institute for Healthcare Improvement. Fewer than one-quarter of hospitals have signed the AHA Equity Pledge. We can conclude, therefore, that commitment to DEI varies considerably. It is difficult to establish a best practices approach when so few organizations have fully implemented DEI initiatives. If these initiatives do exist within health care organizations, it may not be at the level that drives change. Future work should include examining case studies of organizations that have been successful in implementing DEI initiatives and the success of those initiatives.

In this chapter, we have sought to present and distill the body of literature linking health care organizations diversity with health equity improvement. In this effort, we find both challenges and opportunities. The challenges of addressing DEI within the scope of health care organization scholarship cannot be overstated. Health services and health care management researchers have expertise in understanding how health care organizations operate and in

measuring outcomes. There has been, however, an uneven commitment to health equity and health outcomes with current scholarship. Embracing the important work of organizational science within health services research and public health will be important to enhancing understanding of how what happens inside organizations may influence population health, specifically health equity. Health care organizations have an opportunity to contribute significantly, with their unique, dual pursuit of advancing DEI and improving health equity. Studies and research agendas that are able to track the development of health equity initiatives from intention to action to outcome and learning may be able to make more meaningful, lasting contributions to research and ultimately, to building a more equitable health system. This research calls for collaboration, inter- and cross-disciplinary approaches, qualitative and mixed-methods approaches, and other challenges as yet unnamed. The price of not doing this important work, however, is greater than the challenge. If we do not encourage and engage in this difficult work, we will continue to make minimal progress in our noble and collective pursuit of health equity.

REFERENCES

- ACHE (American College of Healthcare Executives). (2008). *A racial/ethnic comparison of career attainments in healthcare management*.
- AHA (American Hospital Association). (2021). The health equity roadmap. Retrieved from <https://equity.aha.org/>
- AHA (American Hospital Association). (2022). Heal: Health equity action library. Retrieved from <https://www.aha.org/heal>
- Allensworth-Davies, D., Leigh, J., Pukstas, K., Geron, S. M., Hardt, E., Brandeis, G., . . . Parker, V. A. (2007). Country of origin and race-ethnicity: Are there differences in perceived organizational cultural competency and job satisfaction among nursing assistants in long-term care? *Health Care Management Review*, 32(4), 321–329.
- Aries, N. R. (2004). Managing diversity: The differing perceptions of managers, line workers, and patients. *Health Care Management Review*, 29(3), 172–180.
- Arndt, M., & Bigelow, B. (2011). The role of mission, organizational culture, and cultural competency in furthering the development of health-care organizations: A commentary. *Advances in Health Care Management*, 10, 69–74.
- Bailey, Z. D., Krieger, N., Agenor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, 389(10077), 1453–1463.
- Beach, M. C., Price, E. G., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., . . . Cooper, L. A. (2005). Cultural competence: A systematic review of health care provider educational interventions. *Medical Care*, 43(4), 356–373.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, 118(4), 293–302.
- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, 24(2), 499–505.
- Blewett, L. A., Hardeman, R. R., Hest, R., & Winkelman, T. N. A. (2019). Patient perspectives on the cultural competence of US health care professionals. *JAMA Network Open*, 2(11), e1916105.
- Brach, C., & Fraser, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(Suppl 1), 181–217.
- Broome, L. L., & Krawiec, K. D. (2008). Signaling through board diversity: Is anyone listening. *University of Cincinnati Law Review*, 77, 431.

- Carter, E. (2020). Restructure your organization to actually advance racial justice. *Harvard Business Review*. Retrieved from <https://hbr.org/2020/06/restructure-your-organization-to-actually-advance-racial-justice>
- CDC. (n.d.-a). Retrieved from <https://www.cdc.gov/minorityhealth/diversityandinclusion/index.html>. Accessed on January 26, 2022.
- CDC. (n.d.-b). Retrieved from <https://www.cdc.gov/chronicdisease/healthequity/index.html>. Accessed on January 26, 2022
- Celani, A., & Singh, P. (2011). Signaling theory and applicant attraction outcomes. *Personnel Review*, 40(2), 222–238.
- Celik, H., Abma, T. A., Klinge, I., & Widdershoven, G. A. (2012). Process evaluation of a diversity training program: The value of a mixed method strategy. *Evaluation and Program Planning*, 35(1), 54–65.
- Chang, A., Martin, R., & Marrapodi, E. (2020). Summer of racial reckoning. Retrieved from <https://www.npr.org/2020/08/16/902179773/summer-of-racial-reckoning-the-match-lit>
- Clark, C. R., Ommerborn, M. J., A Coull, B., Pham, D. Q., & Haas, J. S. (2016). Income inequities and Medicaid expansion are related to racial and ethnic disparities in delayed or forgone care due to cost. *Medical Care*, 54(6), 555–561.
- Cole, A. B., Haun, C. N., & Silvera, G. A. (2022). Mixed signals: An analysis of diversity value signaling in leading U.S. hospitals. *Journal of Hospital Management and Health Policy*, 6, 27.
- Crews, D. C., Collins, C. A., & Cooper, L. A. (2021). Distinguishing workforce diversity from health equity efforts in medicine. *JAMA Health Forum*, 12(2), e214820.
- Curtis, E. F., Dreachslin, J. L., & Sinioris, M. (2007). Diversity and cultural competence training in health care organizations: Hallmarks of success. *Health Care Management*, 26(3), 255–262.
- Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, 18(1), 174.
- Dobbin, F., Schrage, D., & Kalev, A. (2015). Race against the iron cage: The varied effects of bureaucratic personnel reforms on diversity. *American Sociological Review*, 80(5), 1014–1044.
- Dotson, E., & Nuru-Jeter, A. (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. (2007). The role of leadership in creating a diversity-sensitive organization. *Journal of Healthcare Management*, 52(3), 151–155.
- Dreachslin, J. L., Hunt, P. L., & Sprainer, E. (2000). Workforce diversity: Implications for the effectiveness of health care delivery teams. *Social Science & Medicine*, 50(10), 1403–1414.
- Dreachslin, J. L., Weech-Maldonado, R., & Dansky, K. H. (2004). Racial and ethnic diversity and organizational behavior: A focused research agenda for health services management. *Social Science & Medicine*, 59(5), 961–971.
- Dreachslin, J. L., Weech-Maldonado, R., Gail, J., Epané, J. P., & Wainio, J. A. (2017). Blueprint for sustainable change in diversity management and cultural competence: Lessons from the national center for healthcare leadership diversity demonstration project. *Journal of Healthcare Management*, 62(3), 171–183.
- Edelman, A., Taylor, J., Oveiko, P. V., & Topp, S. M. (2017). The role of academic health centres in building equitable health systems: A systematic review protocol. *BMJ Open*, 7, e015435.
- Edwards, L. D., Till, A., & McKimm, J. (2018). Meeting today's healthcare leadership challenges: Is compassionate, caring and inclusive leadership the answer? *BMJ Leader*. Published Online First: 12 April 2018. doi:10.1136/leader-2017-000031
- Evelyn, K. (2020, April 8). "It's a racial justice issue": Black Americans are dying in greater numbers from Covid-19. *The Guardian*. Retrieved from <https://www.theguardian.com/world/2020/apr/08/its-a-racial-justice-issue-black-americans-are-dying-in-greater-numbers-from-covid-19>
- Fisk, J. M., Silvera, G. A., & Haun, C. N. (2019). Developing and defining diversity. *Public Integrity*, 21(3), 286–300.
- Francis, L., Sampson, C. J., & Evans, Sr., R. M. (2021). Diversity, inclusion, and belonging. In C. J. Sampson & B. J. Fried (Eds.), *Human resources in healthcare* (5th ed.). Chicago, IL: Health Administration Press.

- Galstian, C., Hearld, L., O'Connor, S. J., & Borkowski, N. (2018). The Relationship of hospital CEO characteristics to patient experience scores. *Journal of Healthcare Management*, 63(1), 50–61.
- Garcia, M. A., Homan, P. A., Garcia, C., & Brown, T. H. (2020). The color of COVID-19: Structural racism and the disproportionate impact of the pandemic on older black and LatinX adults. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 76(3), e75–e80.
- Gaumer, G., Coulam, R., & Desilets, R. (2021). Minority participation of the senior management of private U.S. hospitals. *Medical Care Research and Review*, 79(3), 435–447.
- Gomez, L. E., & Bernet, P. (2019). Diversity improves performance and outcomes. *Journal of the National Medical Association*, 111(4), 383–392. doi:10.1016/j.jnma.2019.01.006
- Grant, S. (2010). Diversity in healthcare: Driven by leadership. *Frontiers of Health Services Management*, 26(3), 41.
- Gupta, G. R., Oomman, N., Grown, C., Conn, K., Hawkes, S., Shawar, Y. R., ... Gender Equality, N. r., and Health Steering Committee. (2019). Gender equality and gender norms: Framing the opportunities for health. *Lancet*, 393(10190), 2550–2562.
- Hardeman, R. R., Hardeman-Jones, S. L., & Medina, E. M. (2021). Fighting for America's paradise: The struggle against structural racism. *Journal of Health Politics Policy and Law*, 46(4), 563–575.
- Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., ... Gender Equality, N. r., and Health Steering Committee. (2019). Disrupting gender norms in health systems: Making the case for change. *Lancet*, 393(10190), 2535–2549.
- Hefner, J. L., Nembhard, I. M., Stephenson, A. L., Diehl, A. B., Dzubinski, L. M., McErlean, M., ... Sidhu, M. (2021). An exploration of gender bias affecting women in medicine. *Advances in Health Care Management*, 20.
- Herrin, J., Harris, K. G., Spatz, E., Cobbs-Lomax, D., Allen, S., & León, T. (2018). Hospital leadership diversity and strategies to advance health equity. *Joint Commission Journal on Quality and Patient Safety*, 44(9), 545–551.
- Hogan, T. H., Hefner, J. L., Stephens, L., & Lemak, C. H. (2022). Chief diversity officers, who are they and what do they do? *Health Services Management Review*. Accepted for publication.
- HUD. (n.d.). Retrieved from https://www.hud.gov/program_offices/administration/admaabout/diversity_inclusion/definitions
- Hunt, B. (2007). Managing equality and cultural diversity in the health workforce. *Journal of Clinical Nursing*, 16(12), 2252–2259.
- IHI (Institute for Healthcare Improvement). (2021). Health equity. Retrieved from <http://www.ihl.org/Topics/Health-Equity/Pages/default.aspx>. Accessed on January 25, 2022.
- Itchhaporia, D. (2021). The evolution of the quintuple aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology*, 78(22), 2262–2264.
- Kalinoski, Z. T., Steele-Johnson, D., Peyton, E. J., Leas, K. A., Steinke, J., & Bowling, N. A. (2013). A meta-analytic evaluation of diversity training outcomes. *Journal of Organizational Behavior*, 34(8), 1076–1104.
- Krouse, H. J. (2020). COVID-19 and the widening gap in health inequity. *Otolaryngology-Head and Neck Surgery*, 163(1), 65–66.
- Kumra, T., Hsu, Y. J., Cheng, T. L., Marsteller, J. A., McGuire, M., & Cooper, L. A. (2020). The association between organizational cultural competence and teamwork climate in a network of primary care practices. *Health Care Management Review*, 45(2), 106–116.
- Lantz, P. M. (2008). Gender and leadership in healthcare administration: 21st century progress and challenges. *Journal of Healthcare Management*, 53(5), 291–301. Discussion 302–293.
- Lavizzo-Mourey, R. J., Besser, R. E., & Williams, D. R. (2021). Understanding and mitigating health inequities-past, current, and future directions. *New England Journal of Medicine*, 384(18), 1681–1684.
- Leon, R. A. (2014). The chief diversity officer: An examination of CDO models and strategies. *Journal of Diversity in Higher Education*, 7(2), 77–91.
- Lett, E., Adekunle, D., McMurray, P., Asabor, E. N., Irie, W., Simon, M. A., ... McLemore, M. R. (2022). Health equity tourism: Ravaging the justice landscape. *Journal of Medical Systems*, 46, 17.

- Lieu, T. A., Finkelstein, J. A., Lozano, P., Capra, A. M., Chi, F. W., Jensvold, N., ... Farber, H. J. (2004). Cultural competence policies and other predictors of asthma care quality for Medicaid-insured children. *Pediatrics*, 114(1), e102–110.
- Martino, S. C., Elliott, M. N., Hambarsoomian, K., Garcia, A. N., Wilson-Frederick, S., Gaillot, S., ... Haviland, A. M. (2020). Disparities in care experienced by American Indian and Alaska native Medicare beneficiaries. *Medical Care*, 58(11), 981–987.
- Martino, S. C., Elliott, M. N., Hambarsoomian, K., Weech-Maldonado, R., Tamayo, L., Gaillot, S., & Haviland, A. M. (2022). Disparities in care experienced by older Hispanic Medicare beneficiaries in urban and rural areas. *Medical Care*, 60(1), 37–43.
- McCalman, J., Jongen, C., & Bainbridge, R. (2017). Organisational systems' approaches to improving cultural competence in healthcare: A systematic scoping review of the literature. *International Journal for Equity in Health*, 16(1), 78.
- Merriam-Webster. (n.d.-a). Diversity. Merriam-Webster.com dictionary. Retrieved from <https://www.merriam-webster.com/dictionary/diversity>. Accessed on January 26, 2022.
- Merriam-Webster. (n.d.-b). Inclusion. Merriam-Webster.com dictionary. Retrieved from <https://www.merriam-webster.com/dictionary/inclusion>. Accessed on January 26, 2022.
- Merriam-Webster. (n.d.-c). Equity. Merriam-Webster.com dictionary. Retrieved from <https://www.merriam-webster.com/dictionary/equity>. Accessed on January 26, 2022.
- Mitchell, D. A., & Lassiter, S. L. (2006). Addressing health care disparities and increasing workforce diversity: The next step for the dental, medical, and public health professions. *American Journal of Public Health*, 96(12), 2093–2097.
- Mor Barak, M. E., Lizano, E. L., Kim, A., Duan, L., Hsiao, H. Y., Rhee, M. K., & Brimhall, K. C. (2016). The promise of diversity management for climate of inclusion: A state-of-the-art review and meta-analysis. *Human Service Organizations: Management, Leadership and Governance*, 4, 305–333.
- Mousa, M., Boyle, J., Skouteris, H., Mullins, A. K., Currie, G., Riach, K., & Teede, H. J. (2021). Advancing women in healthcare leadership: A systematic review and meta-synthesis of multi-sector evidence on organisational interventions. *EClinicalMedicine*, 39, 101084.
- Nair, L., & Adetayo, O. A. (2019). Cultural competence and ethnic diversity in healthcare. *Plastic and Reconstructive Surgery Global Open*, 7(5), e2219.
- Nundy, S., Cooper, L. A., & Mate, K. S. (2022). The quintuple aim for health care improvement: A new imperative to advance health equity. *JAMA*, 327(6), 521.
- Pinderhughes, R., Bua, A., Alexander, B., King, B., McCaffrey, E., & Onda, T. (2019). *Advancing health equity in San Francisco: An assessment of UCSF's anchor institution capacity and recommendations for strategic direction: Report for the UCSF anchor institution steering committee of the center for community engagement*. Retrieved from <https://anchor.ucsf.edu/sites/g/files/tkssra1391/f/UCSF-anchor-institution-report.pdf>. Accessed on February 21, 2022.
- Santiana, D. (2017, April 28). What is diversity and how I define it in the social context. Retrieved from <https://embracingdiversity.us/what-is-diversity-define-social-diversity/>
- Shaw-Taylor, Y., & Benesch, B. (1998). Workforce diversity and cultural competence in healthcare. *Journal of Cultural Diversity*, 5(4), 138–146. Quiz 147–138.
- SHRM. (2020). *Introduction to the human resources discipline of diversity, equity and inclusion*. SHRM. Retrieved from <https://www.shrm.org/resourcesandtools/tools-and-samples/toolkits/pages/introdiversity.aspx>
- Silvera, G. A., & Clark, J. R. (2021). Women at the helm: Chief executive officer gender and patient experience in the hospital industry. *Health Care Management Review*, 46(3), 206–216.
- Simonsen, K. A., & Shim, R. S. (2019). Embracing diversity and inclusion in psychiatry leadership. *Psychiatric Clinics of North America*, 42(3), 463–471. doi:10.1016/j.psc.2019.05.006
- Smith, S. G., Nsiah-Kumi, P. A., Jones, P. R., & Pamies, R. J. (2009). Pipeline programs in the health professions, part 1: Preserving diversity and reducing health disparities. *Journal of the National Medical Association*, 101(9), 836–851.
- Spence, M. (1978). *Job market signaling. Uncertainty in economics*. Academic Press, 281–306.
- Suazo, M. M., Martínez, P. G., & Sandoval, R. (2009). Creating psychological and legal contracts through human resource practices: A signaling theory perspective. *Human Resource Management Review*, 19(2), 154–166.

- Sullivan, L. W. (2004). Missing persons: Minorities in the health professions, a report of the Sullivan Commission on diversity in the healthcare workforce.
- Thomas, D. A., & Ely, R. J. (1996). Making differences matter: A new paradigm for managing diversity. *Harvard Business Review*, 74(5), 79–90.
- Upadhyay, S., Stephenson, A. L., Weech-Maldonado, R., & Cochran, C. (2021). Hospital cultural competency and attributes of patient safety culture: A study of U.S. hospitals. *Journal of Patient Safety*, 18(3), e680–e686.
- U.S. Census Bureau. (2018). Older people projected to outnumber children for first time in U.S. history. Retrieved from <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>. Accessed on February 21, 2022.
- Vizient. (2021). *Executive report: Keys to investing in health equity & measuring Success*. Retrieved from <https://www.healthleadersmedia.com/roundtable/executive-report-investing-health-equity>. Accessed on January 20, 2022.
- Weech-Maldonado, R., Al-Amin, M., Nishimi, R. Y., & Salam, F. (2011). Enhancing the cultural competency of health-care organizations. *Advances in Health Care Management*, 10, 43–67.
- Weech-Maldonado, R., Dreachslin, J. L., Dansky, K. H., De Souza, G., & Gatto, M. (2002). Racial/ethnic diversity management and cultural competency: The case of Pennsylvania hospitals. *Journal of Healthcare Management*, 47(2), 111–124. Discussion 124–116.
- Weech-Maldonado, R., Dreachslin, J. L., Epané, J. P., Gail, J., Gupta, S., & Wainio, J. A. (2018). Hospital cultural competency as a systematic organizational intervention: Key findings from the national center for healthcare leadership diversity demonstration project. *Health Care Management Review*, 43(1), 30–41.
- Weech-Maldonado, R., Elliott, M., Pradhan, R., Schiller, C., Hall, A., & Hays, R. D. (2012). Can hospital cultural competency reduce disparities in patient experiences with care? *Medical Care*, 50(Suppl), S48–S55.
- Williams, S. D., Hansen, K., Smithey, M., Burnley, J., Koplit, M., Koyama, K., . . . Bakos, A. (2014). Using social determinants of health to link health workforce diversity, care quality and access, and health disparities to achieve health equity in nursing. *Public Health Reports*, 129(Suppl 2), 32–36.
- Williams, D., & Wade-Golden, K. (2007). The chief diversity officer. *CUPA HR Journal*, 58(1), 38–48.
- Woitowich, N. C., Jain, S., Arora, V. M., & Joffe, H. (2021). COVID-19 threatens progress toward gender equity within academic medicine. *Academic Medicine*, 96(6), 813–816.
- Worthington, R. L., Stanley, C. A., Lewis, W. T., & Sr. (2014). National association of diversity officers in higher education standards of professional practice for chief diversity officers. *Journal of Diversity in Higher Education*, 7(4), 227–234.
- Zeh, P., Sandhu, H. K., Cannaby, A. M., & Sturt, J. A. (2012). The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: A systematic review. *Diabetic Medicine*, 29(10), 1237–1252.