

Improving Quality and Performance: Cultural Competence and Workforce Diversity Strategies

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Introduction

The healthcare business landscape is changing. In the wake of the Patient Protection and Affordable Care Act (ACA), newly insured individuals are seeking health care outside of the emergency department setting, bringing an increasingly diverse patient population into the healthcare system. Newer payment models, including value-based purchasing and pay-for-performance programs, create new imperatives for hospitals and healthcare systems to contain costs while improving patient outcomes and ensuring the quality of care for all populations.

The increased emphasis on quality and cost-containment means that many healthcare organizations are seeking to develop and implement innovative approaches to service that incorporate new performance measures. With guidance, more healthcare organizations can expand upon their progress in this area, improving healthcare services, quality, and health outcomes, while having broad community impact.

A key area of focus for these hospitals and healthcare systems is organization-wide cultural competence and workforce diversity, or cultural effectiveness. Achieving cultural effectiveness is predicated upon successfully targeting seven elements – leadership, institutional policies and procedures, data collection, community engagement, language and communication access, staff cultural competence, and workforce diversity and inclusion.¹ Research demonstrates that management practices and administrative policies designed to build a culturally effective organization can improve patient and employee satisfaction, the quality of clinical care delivered, and patient health outcomes.² High performance in the areas of staff cultural competence and workforce diversity can result in an enhanced bottom line resulting from patient satisfaction-based performance incentives. Increased workforce diversity and cultural competence can also lower costs as a result of increased employee retention, more efficient use of interpreter services, and a reduction in unnecessary care and avoidable readmissions that can follow when communication and cultural understanding improve.³ For these reasons, it is just as important to understand the needs of the various racial and ethnic groups that contribute to the rapidly increasing diversity in an organization's catchment area as it is to understand the differing needs of the baby boomer and millennial market segments to which organization are trying to respond.

Although all seven elements contribute to success in becoming a culturally effective organization, this brief focuses on specific indicators and approaches that tie service, quality, and outcomes to the implementation of organizational strategies to improve workforce diversity and cultural competence. In addition to providing an overview of research in the field, the brief includes case studies and resources to facilitate the creation of a strategic plan.

The Bottom Line

Improved staff retention, increased market share, and reduced medical liability expenses are tangible returns on investments in organizational strategies that increase workforce cultural competence and diversity.¹

Hospitals and healthcare systems that understand their patient populations and make quality improvements across all demographic groups will improve overall performance.²

Increasing the diversity of the healthcare workforce improves patient satisfaction, healthcare utilization patterns, and access to care for minority patients.³⁻⁵

¹ Cohen, E., & Goode, T. (1999). Rationale for cultural competence in primary care (Policy Brief No. 1). Washington, D.C.: National Center for Cultural Competence, Georgetown University.

² Mayberry, R., Nicewander, D., Qin, H., & Ballard, D. (2006). Improving quality and reducing inequities: A challenge in achieving best care. *Baylor University Medical Center Proceedings*, (19)2, 103-118.

³ LaVeist, T., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care? *Journal of Health and Social Behavior*, (43)3, 296-306.

⁴ Hampers L., Cha S, Gutglass D., Binns H., & Krug S. (1999). Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*, 103(6 Part 1), 1253-1256.

⁵ Mitchell, D., & Lassiter, S. (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.

Healthcare disparities raise the overall cost of health care. If not actively addressed, a significant area of potential cost-savings will remain unchanged, impacting the healthcare system and broadly impacting community health. For example, minority women in New Hampshire are three times as likely as non-Hispanic Caucasian women to be diagnosed with cardiovascular disease.⁴ The cancer-related death rate in New Hampshire is almost twice as high for non-Hispanic Black women as it is for Caucasian women: 294 per 100,000 non-Hispanic Black women and 150 per 100,000 Caucasian women.⁵ To address variation in treatment and outcomes, government, private payers, and healthcare accrediting bodies are emphasizing the importance of cultural effectiveness.⁶ Culturally effective organizations enable, cultivate, and support the delivery of high-quality health care for all groups of people.⁷ Work in this area is already underway to address gaps in health equity in New Hampshire.⁸

Research shows that employing a workforce that reflects the cultural, ethnic, and linguistic diversity of the community an organization serves, while simultaneously achieving cultural competence benchmarks, can have multiple benefits. These benefits can include a reduction in average inpatient length of stay and avoidable readmissions, an increase in treatment adherence, improved patient satisfaction ratings, more appropriate service utilization patterns, and enhanced operating efficiencies.⁹ Thus, workforce diversity and cultural competence strategies can play an important role in organizational efforts to improve financial results and enhance services for an increasingly diverse population.

The Case for Change

Healthcare organizations that have diversified their workforce and enhanced their cultural effectiveness report numerous beneficial outcomes for patients and for the businesses themselves. There likely are additional benefits that have not been reported publicly, as these efforts are works-in-progress. Research on the impact of workforce diversity and cultural competence has found that:

- ▶ Healthcare workforce diversity affects patient health outcomes, treatment adherence, safety, satisfaction, and quality of care.¹⁰
- ▶ Workforce diversity is associated with improved patient-provider communication.¹¹
- ▶ Racial and ethnic concordance in patient-provider relationships can increase patient engagement.¹²
- ▶ Patients with limited English-speaking abilities have better health outcomes, receive higher quality care, and report higher satisfaction when they have access to trained professional interpreters and bilingual/multilingual staff members.¹³
- ▶ Organizations that possess greater levels of cultural competence earn higher scores on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey in the areas of communication, effective pain control, and staff responsiveness.¹⁴

Documented Cost-Savings

Language Interpretation

- Lower contract interpreter costs¹
- Reduced communication delays between providers and patients¹
- Reduced system inefficiencies (e.g., wait time for interpreters)¹

Service Utilization

- Decreased inappropriate utilization¹
- Shortened length of stay¹
- Increased utilization of profitable services¹
- Expanded total number of patients¹

Staff Productivity

- Improved discharge capacity¹
- Enhanced overall productivity¹

Meeting Joint Commission Standards

- Serve patients' communication needs²
- Accommodate patients' cultural and ethnic needs²

¹ Cobb, A.J. (2007). Making the business case for culturally and linguistically appropriate services in health care: Case studies from the field. Washington, D.C.: Alliance of Community Health Plans Foundation. Retrieved from <http://minorityhealth.hhs.gov/Assets/pdf/Checked/CLAS.pdf>

² The Joint Commission. (2014). A Crosswalk of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care to The Joint Commission Hospital Accreditation Standards. Retrieved from <http://goo.gl/hQYEZU>

Definitions

Culturally Effective Organization

An organization with leadership that formally acknowledges the importance of organizational cultural competence through policy-setting, organization-wide training, performance monitoring, data collection, patient communication, care delivery that is sensitive to diverse needs, targeted human resources strategies, and community engagement.¹⁵

Cultural Competence

A set of attitudes, skills, behaviors, and policies that enable staff members to work effectively in cross-cultural situations.¹⁶

Workforce Diversity:

A workforce composed of a range of diverse employees (by culture, race/ethnicity, language, etc.) represented at all levels of the organization.¹

Workforce Inclusion

Creating an accepting environment where differences are honored, all employees feel valued and respected, and where staff members have the confidence to do their best work.¹⁷

Racial and Ethnic

Healthcare Disparities

“Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, [or] appropriateness of intervention.”¹⁸

Examples of Performance Measures

Clinical Measures Disaggregated by Race/Ethnicity & Language Status

- Ambulatory care-sensitive readmissions¹
- Avoidable emergency room visits²
- Length of stay measured in hours²
- Inappropriate test ordering²
- Sentinel disparity indicators (e.g., pain management in the emergency department)³
- HEDIS outcome measures

Patient & Employee Satisfaction Disaggregated by Race/Ethnicity & Language Status

- Patient satisfaction scores⁴
- Number of patient complaints
- Diverse employee satisfaction scores⁵
- Employee discrimination complaints⁵

Cultural Competence

- Pre/post staff cultural competence training knowledge assessment scores
- Chart review documenting clinician behavior change⁶
- Patient experience questions disaggregated by race, ethnicity, and language

Operations

- Waiting time for new clinical appointments for those requiring interpreters⁷
- Cost of contract interpretation services¹
- Number of in-person vs. telephone interpreter contacts¹

Human Resources Disaggregated by Race/Ethnicity

- Staff hiring, retention, and advancement rates
- Staff absenteeism
- Demographic composition of senior leadership and board of directors⁸
- Proportion of diverse employees at each job level⁹

¹ Cobb, A.J. (2007). Making the business case for culturally and linguistically appropriate services in health care: Case studies from the field. Washington, D.C.: Alliance of Community Health Plans Foundation. Retrieved from <http://minorityhealth.hhs.gov/Assets/pdf/Checked/CLAS.pdf>

² Betancourt, J. (2006). Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care. Retrieved from <http://tinyurl.com/q5ey6d8>

³ Thorlby, R., Jorgensen, S., Seigel, B., & Ayanian, J. (2011). How health care organizations are using data on patients' race and ethnicity to improve quality of care. *The Milbank Quarterly*, 89(2), 226-255.

⁴ Health Research & Educational Trust. (2013). Becoming a culturally competent health care organization. Retrieved from <http://tinyurl.com/pcgqecx>

⁵ Brenman, M. (2012, November 24). Diversity metrics, measurement, and evaluation. Retrieved from <http://tinyurl.com/nz4sbab>

⁶ Betancourt, J., & Green, A. (2010). Linking cultural competence training to improved health outcomes: Perspectives from the field [Commentary]. *Academic Medicine*, 85(4), 583.

⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration. (2001). Cultural competence works: Using cultural competence to improve the quality of health care for diverse populations and add value to managed care arrangements. Retrieved from <http://tinyurl.com/nfsbbc5>

⁸ American Hospital Association. (2004). Strategies for leadership: Does your hospital reflect the community it serves?: A diversity and cultural proficiency assessment tool for leaders. Retrieved from <http://goo.gl/2XmT5t>

⁹ Gallagher-Louis, C. (2013, July). The ROI of D&I: Why municipalities must measure their efforts in equity, diversity and inclusion. Retrieved from <http://www.ccdi.ca/whats-happening/in-the-news/mw-roi/>

¹ In this document, use of the term “diversity” is limited to racial, ethnic, and linguistic diversity. However, creating a culturally effective organization requires attention to all aspects of diversity, including age, gender and sexuality, physical and mental disabilities, religion, etc.

Measuring Success

A wide variety of resources and tools are available for those looking to measure the success of their workforce diversity and/or cultural competence strategies. In addition to consultancies that specialize in advising organizations on such assessments, printed and electronic tools are available for those who choose to assess their outcomes independently (see Resources). Some of these tools also may be useful for assessing organizational readiness in the period leading up to accreditation visits, or in assessing progress toward meeting Enhanced National CLAS Standards.¹⁹ For example, users of a cultural competence assessment tool created by The Lewin Group indicated that the instrument was helpful in preparing the organization for a Joint Commission accreditation visit.²⁰

Measuring progress within both the inpatient and outpatient environments can provide the organization's leadership with rich data that may highlight a need for broader strategies or validate the wide-reaching success of current work. This can be approached by measuring smaller organizational units. For example, organizations may measure and make comparisons across departments and hospital-affiliated practices.²¹ The following table provides additional examples of useful approaches to the assessment process.

Select Evaluation Research Options			
Type of Assessment	Unit of Measure	Possible Measures	Primary Audience
Patient satisfaction	Individual	Number of patient and family complaints, satisfaction with quality of care received, self-reported patient understanding of discharge instructions, and satisfaction with interpreter services (if used)	Leadership, clinical staff, Patient and Family Advisory Council (PFAC), and community leaders
Patient and staff demographics	Individual	Patient and staff member race, gender, age, primary language, etc.	Leadership, clinical staff, and human resources
Patient health outcomes (to identify treatment variation)	Individual	Quantitative clinical health outcomes (e.g., post-visit BP or A1c, mortality rates, nosocomial infection rates) and patient-reported outcomes (e.g., incidence of difficulty performing ADL)	Leadership and clinical staff
Community needs	Catchment area	Environmental scan of services already in existence, analysis of services needed, trends in community demographics, etc.	Leadership, PFAC, and community leaders
Operations	Organization	Cultural appropriateness of meal selections, signage, patient education materials, and legal documents (both complexity and language interpretation)	Leadership, PFAC, and legal counsel
Staff cultural competence	Organization and individual	Knowledge, attitude change, and evidence of behavior change (e.g., documented through clinical chart review)	Leadership, human resources, and community leaders
Staffing	Organization	Staff diversity, retention rates, and grievance rates disaggregated by race/ethnicity and primary language	Leadership and human resources

Key Lessons from the Field and the Literature

Healthcare organizations that implement and evaluate cultural competence and workforce diversity strategies learn important lessons along the way. Some have found that engaging “linguistically appropriate services” is the best first step toward cultural effectiveness.²² Focused attention on the professional development of bilingual and multilingual employees has been key to many organizations that have achieved cultural effectiveness.²³

Performance assessment during and after the implementation of cultural competence and workforce diversity interventions should be part of any planned effort.²⁴ It is essential to strive to collect high-quality data. High-quality data helps ensure the rigor and usefulness of performance assessments intended to measure success. Through interviews with key researchers in the field, as well as a review of the literature, the authors have identified both data-specific lessons, as well as general lessons, that are applicable to most healthcare organizations that seek to move forward with their cultural effectiveness work.

Conceptualize the Performance Assessment

- ▶ Develop a common understanding of how the organization defines cultural competence, workforce diversity and inclusion, and disparity.
- ▶ Identify the organizational level that the intervention is designed to impact: a) the entire organization, b) a single department or sub-group, or c) individuals involved directly or indirectly with care delivery.
- ▶ Delineate specific desired changes, such as clinical process, clinical outcomes, employee behavior change, reduction in adverse health events, return on investment, etc.
- ▶ Determine which process and/or outcome variables would best measure the desired changes.
- ▶ Design an intervention drawing on existing evidence linking cause and effect for the challenge being addressed.
- ▶ Include culturally and linguistically diverse staff and/or external stakeholders in the planning and implementation of the intervention.

Ensure Quality of Data

- ▶ Collect baseline data to compare to future data collection periods.
- ▶ Consider whether there will be enough data to generate statistically significant results. If samples are small, consider combining data collected during a longer time period.
- ▶ Make use of qualitative methods (e.g., interviews and focus groups) to help explain quantitative findings from surveys, etc.
- ▶ Use direct measures of minority patient experience on patient surveys (e.g., measures of patients’ perceptions of staff cultural sensitivity, respect, and discrimination).
- ▶ Disaggregate the data by race, ethnicity, and language during analysis to determine whether different outcomes exist for diverse groups.

Facilitate Data Collection and Access

- ▶ Update race, ethnicity, language, and contact information on an ongoing basis when patients go through the registration process to save time and money, as well as to facilitate the sampling process that occurs before an internal assessment.
- ▶ Use multiple methods of data collection when gathering feedback from diverse patients to ensure their ability to participate if facing language or other barriers (e.g., focus groups offered in languages other than English).
- ▶ Provide patients with easy-to-understand materials in multiple languages and use interpreters to ensure communication access and full patient participation in assessments.
- ▶ Ensure that patient race, ethnicity, and language information is shared across the organization and available to all staff who have access to patient records (e.g., clinical, billing, etc.).

Involve Leadership Throughout the Process

- ▶ Directly involve leadership from the beginning to facilitate organizational change.
- ▶ Provide leadership with the rationale for implementing the strategy and conducting the performance assessment.
- ▶ Utilize performance assessment results to facilitate organizational growth at every level.

Reporting on Performance

The U.S. Department of Health and Human Services Office of Minority Health (OMH) encourages healthcare organizations to make information about successful cultural effectiveness innovations available to the public.²⁵ While not all findings are appropriate for public dissemination, OMH recommends that organizations publicly report on the findings of cultural effectiveness assessments.²⁶ Organizations that implement strategies addressing the components of cultural effectiveness covered in this report may consider publicly reporting the following findings:

- ▶ Demographic breakdown of the patient population
- ▶ Statistics about the availability and use of interpreters and translated materials
- ▶ Levels of staff linguistic and cultural competence training
- ▶ Expenditures related to the implementation of CLAS-related strategies, as well as corresponding cost-benefit/ROI data
- ▶ Satisfaction ratings (patient and/or employee) and findings related to performance measures, clinical outcomes, quality improvement, and cost-effectiveness

Healthcare organizations often choose to report healthcare disparities findings publicly to reinforce and/or strengthen a commitment to working with the community and to build trust through transparency. Working with community organizations that serve diverse populations can be a useful way of informing past and potential patients about the progress that has been made in the areas of cultural competence and workforce diversification. Organizations may use the opportunity to provide a chance for the community to offer feedback about assessment findings. Such discussions and educational forums can help organizations determine whether the internal recommendations resulting from the assessment meet the needs of various community groups.²⁷

Moving Forward

As noted earlier, the authors have identified numerous beneficial outcomes reported by organizations that have implemented or worked to improve the elements of cultural effectiveness described here. The use of performance measures to capture the effectiveness of such strategies reveals their impact on outcomes related to patients, the organization, and the organization's employees. Because research in this area is in its infancy, reporting assessment findings publicly enables the healthcare sector to benefit from new knowledge, speeding progress and innovation. Evolving knowledge, best practices, and new data will help healthcare organizations in New Hampshire and across the country improve their bottom lines and ensure the quality of health care for all.

Massachusetts General Hospital's Center for Diversity and Inclusion

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Challenge

The Massachusetts General Hospital (MGH) determined that its routine patient experience surveys excluded or underrepresented the hospital's racial, ethnic, and linguistic minority patients. Thus, findings from previous MGH surveys may not have been representative of its patient population.

New Initiatives

MGH implemented several interventions, including: 1) a patient activation poster campaign (in English and Spanish) which encouraged patients to get involved in clinical quality improvement and the prevention of medical errors, 2) quality and safety rounds which highlighted the issues of healthcare disparities at the provider level, 3) a cross-cultural training initiative that involved training frontline staff and focused on improving patient care and cross-cultural communication, and 4) an initiative called "Service Matters," which focused on building a frontline staff culture of service.

This case study describes the ongoing internal assessment of the multiple workforce diversity and cultural competence initiatives MGH implemented, as well as the impact these initiatives have had on patient satisfaction and the experiences of racial/ethnic minorities.

Assessment Process

MGH conducts assessments to measure the impact of its cultural/linguistic competence and workforce diversity/inclusion initiatives on the following outcomes: 1) quality of patient care, 2) providers' knowledge, 3) perceived skills of physicians and other staff after receiving cultural competence training, and 4) progress in employment diversity for clinical and non-clinical staff at MGH. Some assessments provide a point-in-time snapshot of staff diversity or the climate within various programs and services. The MGH is also conducting ongoing pre- and post-assessments of staff and faculty who are receiving cultural competence training.

In addition, the hospital asks patients to complete surveys in order to measure the effects of its initiatives on the patients it serves. The initial (baseline) assessment that was conducted prior to implementation of the initiatives described above was administered to 400 ambulatory patients in 2004. In 2012, the survey was repeated with 852 patients (children and adults) and expanded to include non-English speakers.

Prior to the administration of the 2012 survey, MGH updated the survey instrument with additional measures to capture information about language interpretation services and communication with patients who have limited English proficiency. The new survey also included questions related to gender and religious concordance between patients and providers. Patients responded to questions about whether they thought doctors and nurses spent enough time with them, whether clinicians explained things in a way that they could understand, whether patients felt welcomed by staff, and whether they felt that they received the same quality of care as other patients.

To obtain a higher survey response rate, MGH employed several strategies, including statistical sampling techniques, bilingual study materials, and telephone interviews conducted by trained bilingual interviewers.

Outcomes or Impact

At the time of the 2004 survey, 21% of African American patients and 25% of Hispanic/Latino patients reported a perception that they had received lower quality of care compared to Caucasian, English-speaking patients. After the interventions had been in place for several years, the 2012 survey revealed that fewer than 10% of African American and Hispanic/Latino patients felt they had received lower quality care. Additionally, four questions pertaining to patient-provider communication and trust received ratings of “highly effective” by 72 to 86% of respondents in 2004, which improved in 2012 to 79 to 95% of respondents. The percentage of patients who reported feeling welcomed “never/sometimes” decreased significantly from 26% in 2004 to 11% in 2012.

Lessons Learned

The organization reports learning several lessons during the process of its internal assessments:

- Update race, ethnicity, and language information on an ongoing basis as a regular part of the patient registration process to save time and money, and support the assessment sampling process
- Employ multiple modes of data collection when gathering the opinions of diverse populations; qualitative data can help explain quantitative survey data
- Investigate patient experience among minority populations by using direct measures of discrimination, cultural sensitivity, and respect, alongside commonly used quality benchmarks
- Collect data during longer periods of time to facilitate analysis for small demographic groups

The organization used its assessment results to identify areas in need of improvement and to determine the best approach for future assessment and survey delivery for diverse populations. The MGH has taken several steps to address issues highlighted by the findings:

- Renewed focus on ensuring that patients are aware that interpreter services are free of charge
- Providing health-related materials in multiple languages
- Recognition of the complexity of language preference for medical care, surveys, and registration
- Internal dissemination of data at multiple levels of the hospital to drive quality improvements

Sources:

Breaking barriers to hear all voices, (2013, April 12). In MGH Hotline Online. Retrieved from <http://www.massgeneral.org/about/newsarticle.aspx?id=4124>

Donelan, K., & Betancourt, J. (2013, October 22). Hearing all voices: Race, ethnicity, language and the patient experience [Webinar]. In the Disparities Solutions Center’s Web Seminar Series. Retrieved from <http://link.videoplatform.limelight.com/media/?mediaId=8d9778ce0d4f4a158e3972f2a508ceab&width=480&height=321&playerForm=Player>

K. Donelan, personal communication, July 24, 2014 and September 14, 2015

E. Olson, personal communication, February 2014

Diversity Leadership Demonstration Project

National Center for Healthcare Leadership (www.nchl.org)

1700 W. Van Buren, Suite 126B, Chicago, Illinois 60612

Challenge

The National Center for Healthcare Leadership's (NCHL) Diversity Leadership Demonstration Project involved the pre-post assessment of an intervention designed to improve workforce diversity and cultural competence in two health systems. Matched control and intervention hospitals were randomly assigned in each system.

New Initiative

The intervention included infrastructure development (human resource management systems), executive coaching, training (basic awareness training and additional advanced and customized training), individual-level staff and executive action planning, and other individual-level interventions.

Assessment Process

The project involved several phases, including pre-intervention assessment, feedback and consultation, organization-level action planning, an intervention period, post-intervention assessment, post-intervention feedback, and planning for sustainable change and continuous improvement. Intervention hospitals were engaged in all phases of the project, while control hospitals were involved in the pre- and post-intervention assessments only.

Pre-intervention assessments were administered at the individual-, organizational-, and team-levels. Structured interview and focus group findings revealed the pre-intervention diversity climate and management/staff perceptions of existing levels of cultural competence. Subsequently, a diversity coach provided feedback to the CEO and leadership teams at the intervention hospitals enabling the development of an organizational-level action plan to be implemented at the intervention hospitals.

Post-intervention assessments employed the same tools as those used during the pre-intervention assessment. The pre-post assessment battery evaluated the intervention's impact on organizational and individual competencies, as well as on human resource and patient experience outcomes. After completion of the project, the diversity coach provided the CEO and leadership with assistance in planning for sustainable change.

Outcomes and Impacts

Six of the project's nine hypotheses were supported or partially supported. Intervention hospitals outperformed their respective controls on all three individual-level competencies: diversity self-awareness, implicit bias reduction, and racial identity status development. Intervention hospitals also outperformed their respective controls on three of the four organization-level competencies: diversity leadership, strategic human resource management, and diversity climate. However, the intervention's impact on hospital-wide outcomes such as staff cultural competency, inpatient experiences of care, and workforce diversity was mixed. While the findings lend support to the benefits of adopting a systems approach as a strategy for diversity management and improving cultural competence in hospitals, no clear connection could be drawn between improved diversity management practices/cultural competence and financial/patient outcomes. As outcomes data become more robust in the nation's hospitals, future studies can build on the demonstration project's findings and further explore the impact of diversity and cultural competence practices on outcomes.

Pre-Post Intervention Organizational Change Assessment Results

Cultural Competency Assessment Tool for Hospitals (CCATH) – The CCATH assesses hospital adherence to the Culturally and Linguistically Appropriate Services (CLAS) Standards. Results demonstrated greater post-intervention improvement at the intervention hospitals for the CCATH diversity leadership dimensions. However, results were mixed for the CCATH patient cultural competency dimensions, with one intervention hospital experiencing improvement, but not the other.

National Healthcare Leadership Index – Post-intervention improvement in leadership practices (e.g., learning and development, performance management, and succession planning) at the intervention hospitals was greater than at the control hospitals.

Organizational Climate Survey (OCS) – Results were mixed for this self-assessment of diversity and cultural proficiency. One system's intervention hospital showed an increased gap between perceived and ideal climate across all measured dimensions post-intervention. The other intervention hospital reduced the gap between perceived and ideal climate on all dimensions except "Rewards." The OCS was not administered pre- or post-intervention at the control hospitals due to project budgetary constraints.

Diversity Perceptions Scale (DPS) – Differences in DPS scores were observed across the two systems. One system's intervention hospital experienced positive change in both organizational inclusion and organizational fairness. The second system's intervention and control hospitals both had negative change scores, but the intervention hospital showed a lesser degree of negative change than the control hospital.

NCHL Organizational Diversity and Cultural Proficiency Assessment – This assessment measures five domains: diversity leadership, strategic orientation, diversity infrastructure, professional development, and culture/climate. Results for this assessment were mixed. One intervention hospital experienced greater pre-post improvement than its matched control across all five dimensions, but the second intervention hospital did not.

Pre-Post Intervention Individual Change Assessment Results

Discovering Diversity Profile – Intervention hospitals in both systems experienced greater improvement on most dimensions of this survey compared to their respective control hospitals. The survey assesses four areas: knowledge, understanding, acceptance, and behavior.

Implicit Attitude Test – Differences were observed in implicit attitude scores across both systems. Compared to its control, one intervention hospital experienced a greater reduction in staff preference both for young people and Caucasians. The second intervention hospital experienced a reduction in preference for Caucasians, but an increased preference for younger people relative to its control hospital.

The Black Racial Identity Attitude Scale (BRIAS) and the White Racial Identity Attitude Scale (WRIAS) – Caucasian staff at the intervention hospitals experienced deterioration in their racial identity profile as evidenced by lower WRIAS scores on some dimensions (Immersion/Emersion and Autonomy) compared to the control hospitals. However, African Americans at the intervention hospitals in both systems experienced improvements in their racial identity profiles compared to their control hospitals.

Lessons Learned

Leadership reports gaining several new insights from this project, including: 1) the value of opening a discussion on diversity and inclusion, 2) the importance of leadership in facilitating organizational change, 3) the organizational improvements that can result from interventions such as those in the study, and 4) a better understanding of the many dimensions of diversity.

Sources:

- Barak, M. (2013). *Managing diversity: Toward a globally inclusive workplace*. Thousand Oaks: Sage Publications.
- Dreachslin, J. (2011, October). *Organizational cultural competence*. Paper presented at the Cross Cultural Health Care Conference, Honolulu, HI.
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- Dreachslin, J. (2014, June). *From diversity to inclusion: The role of C-suite leadership*. [PowerPoint slides]. Presented at the National Leadership and Education Conference, Chicago, IL. Retrieved from http://www.diversityconnection.org/diversityconnection/leadership/conferences/2014%20Confl/o20Docs/Part_1.pdf
- J. Dreachslin & R. Weech-Maldonado, personal communication, June 5, 2014 and September 14, 2015

Resources

Annotated Descriptions of Measurement Tools

Organization-Level

Cultural Competency Assessment Tool for Hospitals (CCATH)

<http://goo.gl/D2yM8p>

The CCATH assesses hospital adherence to national standards for culturally and linguistically appropriate services (CLAS) in health care which were established by the U.S. Department of Health and Human Services Office of Minority Health. The survey consists of 12 domains covering leadership and strategic planning, data collection, human resource practices, community engagement, language and communication access, staff cultural competence, and diversity training.

National Healthcare Leadership Index

<http://www.nchl.org/static.asp?path=2852,3241>

The National Healthcare Leadership Index can be administered to hospital CEOs to assess leadership practices in areas such as diversity and cultural proficiency, leadership development, and governance. The Index compares a healthcare organization's leadership development practices with the National Center for Healthcare Leadership's (NCHL) evidence-based best practices in health care and in private industries. The feedback report shows how participating organizations, as an aggregate group, compare to other healthcare organizations and how all healthcare organizations compare to benchmark organizations.

Organizational Climate Survey (OCS)

http://www.haygroup.com/leadershipandtalentondemand/ourproducts/item_details.aspx?itemid=51&type=1&t=2

The OCS measures staff members' perception of "what it's like to work here" and aspects of the environment that directly impact employees' ability to do their jobs well. This assessment measures organizational climate along six dimensions: flexibility, responsibility, standards, rewards, clarity, and team commitment. It also measures how well organizational leaders optimize their human resources. The OCS shows the climate that leaders experience, the climate that employees experience, and any differences that exist between the two.

NCHL Organizational Diversity and Cultural Proficiency Assessment

<http://www.aha.org/aha/content/2004/pdf/diversitytool.pdf>

This diversity and cultural proficiency self-assessment is completed by executive leadership and staff. The instrument assesses 12 domains: diversity leadership, diversity-sensitive orientation, strategic orientation, diversity infrastructure, audits/assessments, accountability, professional development, formal mentoring programs, affinity groups, work/life balance, flexible benefits, and culture/climate. The assessment includes an analysis of any gaps that exist between leadership and staff perceptions. This tool enables organizations to compare current practices with best practices that not only facilitate career advancement for women and racially/ethnically diverse individuals, but also provide the organizational supports clinicians need to deliver care that is culturally competent.

Cultural Competency Implementation Measure

<http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=1919&print=0&entityTypeID=1>

This is an organizational survey designed to be used by healthcare organizations to identify the degree to which they are providing culturally competent care and addressing the needs of diverse patients. It measures adherence to 12 of the 45 cultural competence practices endorsed by the National Quality Forum. In addition to assessing quality improvement, information from the survey can be used to establish benchmarks to document progress over time and provide comparisons to peer organizations.

Pro Mosaic II – The Diversity/Inclusion Assessment Tool

<https://4good.org/jonathan-peizer--14/pro-mosaic-ii-the-diversity-inclusion-assessment-tool>

This tool evaluates the quality, impact, and productivity of organizational diversity/inclusion strategies.

Individual-Level

Discovering Diversity Profile

<http://www.profiles4u.com/disc-profile-diversity.asp>

This is a self-administered survey that assesses stages of racial identity against a theoretical model in four areas: knowledge, understanding, acceptance, and behavior. The Discovering Diversity Profile helps employees learn how they respond to workforce diversity and recognize where they need to develop increased understanding. Organizations use it to limit the influence of stereotypes, reduce conflict, and embrace diversity.

Implicit Attitude Test (IAT)

<https://implicit.harvard.edu/implicit/iatdetails.html>

This is a self-administered, internet-based test that measures the strength of associations between concepts (e.g., black people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy). Results are stripped of identifiers and analyzed by a research team to assess the existence of implicit bias.

The Black Racial Identity Attitude Scale (BRIAS) and the White Racial Identity Attitude Scale (WRIAS)

<http://www.statisticssolutions.com/racial-identity-attitude-scale-rias/>

The RIAS scales are self-reported scales that evaluate attitudes across four schemas: pre-encounter, encounter, immersion, and internalization. The general scale can be used for all races and more specific versions exist for specific races.

Guidance for Use of Measurement Tools and Related Readings

- Wilson-Stronks, A., Lee, K., Cordero, C., Kopp, A., & Galvez, E. (2008). *One size does not fit all: Meeting the health care needs of diverse populations*. Oakbrook Terrace, IL: The Joint Commission.
<http://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf#page=47>
- Enhanced National CLAS Standards <https://www.thinkculturalhealth.hhs.gov/content/clas.asp>
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<http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>
- Joint Commission accreditation and certification standards
http://www.jointcommission.org/accreditation/hap_standards_information.aspx
- The Lewin Group. (2002, April). *Indicators of cultural competence in health care delivery organizations: An organizational cultural competence assessment profile*.
<http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf>
- Stratified Press Ganey patient satisfaction surveys (disaggregate by race, ethnicity, and language)
<http://www.pressganey.com/ourSolutions/patient-voice.aspx>
- CAHPS® (Consumer Assessment of Healthcare Providers and Systems) <https://cahps.ahrq.gov/>
- HEDIS measures <http://www.ncqa.org/HEDISQualityMeasurement/HEDISMeasures.aspx>
- National Center for Cultural Competence self-assessment tools and resources
<http://nccc.georgetown.edu/resources/assessments.html>
- The Denver Foundation's Inclusiveness Project Readiness Exam <http://www.nonprofitinclusiveness.org/node/55>
- Coordinated Care Services Inc. Cultural Competence Readiness Assessment Questionnaire
<http://www.tapartnership.org/docs/ccReadinessQuestionnaire.pdf>
- Harvard Business Review: Is yours a learning organization? Diagnostic survey
https://hbs.qualtrics.com/SE/?SID=SV_b7rYZGRxuMEyHRz
- CLAS A-Z: A practical guide for implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care http://minorityhealth.hhs.gov/assets/pdf/checked/CLAS_a2z.pdf
- America's Health Insurance Plans. (2005). *Tools to address disparities in health: Data as building blocks for change. A data collection toolkit for health insurance plans/health care organizations*.
<http://www.vdh.virginia.gov/ohpp/clasact/documents/CLASact/research/default.pdf>
- National Health Plan Collaborative toolkit to reduce racial & ethnic disparities in health care
<http://www.rwjf.org/content/dam/farm/toolkits/toolkits/2008/rwjf31198>
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<http://www.mathematica-mpr.com/publications/PDFs/health/disparitieshealthcare.pdf>
- Guidance to hospitals on collecting race, ethnicity, and language data
<http://www.healthynh.com/images/nhhep/Workforce%20Diversity%20Issue%20Brief.pdf>
- Culturally and linguistically appropriate care resources
<http://www.healthynh.com/images/PDFfiles/cultural-effectiveness/CLASResources.pdf>
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<http://www.rwjf.org/content/dam/farm/toolkits/toolkits/2008/rwjf24722>
- The Affordable Care Act and limited English proficient populations: Key implications for healthcare providers
<http://www3.cyracom.com/ACAwhitepaper>
- Harper, M., Hernandez, M., Nesman, T., Mowery, D., Worthington, J., & Isaacs, M. (2006). *Organizational cultural competence: A review of assessment protocols (Making children's mental health services successful series, FMHI pub. no. 240-2)*. Tampa, FL: University of South Florida.
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Endnotes

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