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Katherine Counts
University of Kentucky, katherine.counts@yahoo.com
Author ORCID Identifier:

https://orcid.org/0000-0003-4812-7038
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Katherine Counts, Student

Dr. Kristina Hains, Major Professor

Dr. Patricia Dyk, Director of Graduate Studies

UNDERSTANDING PERSPECTIVES OF CLINICAL AND NON-CLINICAL HEALTHCARE ADMINISTRATORS ON CULTURE AND DIVERSITY IN THE HEALTHCARE WORKPLACE

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Community and Leadership Development in the College of Agriculture, Food and Environment at the University of Kentucky

By
Katherine Counts
Lexington, Kentucky
Director: Dr. Kristina Hains, Associate Professor and Extension Specialist in Leadership Development

Lexington, Kentucky
2021

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https://orcid.org/0000-0003-4812-7038

ABSTRACT OF THESIS

UNDERSTANDING PERSPECTIVES OF CLINICAL AND NON-CLINICAL HEALTHCARE ADMINISTRATORS ON CULTURE AND DIVERSITY IN THE HEALTHCARE WORKPLACE

The racial and ethnic composition of the U.S. population is becoming increasingly more diverse. The 2010 U.S. Census reported a 29% increase in minority groups other than non-Hispanic Whites. In response to these changing demographics, healthcare organizations have struggled to keep pace with these trends in their hiring of a diverse staff. Healthcare leaders appear to be lagging in their efforts to make adequate changes to increase diversity in their organizations. What factors may be contributing to this inequity? One possible explanation is a limited knowledge of healthcare leaders regarding culture and diversity within the workplace. To this end, this study explores the individual cultural intelligence of clinical and non-clinical administrative healthcare leaders, while also shedding light on leadership perspectives of cultural metrics in the workplace. Initial conversations with university-based healthcare leaders shed light on the need to understand the value placed on creating a diverse teams and the role that cultural understanding plays in understanding and working with others who are different from ourselves.

KEYWORDS: Diversity, Cultural Intelligence, Cultural Humility, Healthcare Administration, Leadership, Healthcare

Katherine Counts

(Name of Student)

04/05/2021

Date

UNDERSTANDING PERSPECTIVES OF CLINICAL AND NON-CLINICAL HEALTHCARE ADMINISTRATORS ON CULTURE AND DIVERSITY IN THE HEALTHCARE WORKPLACE

By

Katherine Counts

Dr. Kristina Hains

Director of Thesis

Dr. Patricia Dyk

Director of Graduate Studies

04/05/2021

Date

DEDICATION

To those who are striving to make a difference in the lives of your patients, *I see you.*
To those who are currently trying to break glass ceilings in a culture where you are the marginalized person, *I hear you.*
I see the changes that are being made, and *I know that this new generation will create a more equitable world.*

I want to dedicate this work to my family and friends for their love and support.

ACKNOWLEDGMENTS

I want to thank those who have made an impact in my research journey. I want to thank my professors for helping me navigate this new chapter of my life as well as answering all my questions and for always being supportive.
These individuals have expanded my lens and perspectives of research and my future endeavors. Even in the midst of a global pandemic, I was able to finish my thesis. Through many revisions, questions, and feedback here is a list of those I want to thank for making this thesis possible:

First, I want to thank my Thesis Chair, Dr. Kristina Hains. Thank you for always believing in my vision and helping me to see it come to light. Your guidance and support were instrumental in helping me pick a path within my research and never giving up on the plan.

Thank you to my entire committee for being patient with me during the COVID-19 pandemic, especially Dr. Patricia Dyk for giving me feedback and ways to adjust my project to fit my timeframe and also suggesting ways to analyze my data. Thank you to all of the professors and graduate students that have helped me along this journey of graduate school!

I also want to thank Dr. Tukea Talbert for helping me to understand diversity from an administrative viewpoint and answering so many questions on the subject. I want to thank Dr. Vanessa Jackson for her continual encouragement to continue in higher education and reminding me to never give up! I want to also thank Dr. Joseph Benitez, Dr. Brandi White, Dr. Mia Farrell and Dr. Nicole Breazeale for our discussions about diversity, equity, and my future career paths.

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CHAPTER 1. INTRODUCTION

1.1 Introduction

Throughout history, but especially in the last 20 years, there has been a shift in the demographics in the United States. As of 2010, the U.S. Census Bureau stated that there had been a 29% increase in racial and ethnic diversity (US, 2010). The U.S. population is estimated to increase from 319 million to more than 400 million by 2051 (Colby & Ortman, 2014; Myers & Dreachslin, 2007), with nearly 1 in 5 Americans estimated to be foreign-born by 2060 (Colby & Ortman, 2014; Myers & Dreachslin, 2007; Saunders Russell & Augustin, 2017). Furthermore, U.S. Census data estimates that 18% of American homes will speak a language other than English (Dreachslin, 2007; Shin & Bruno, 2003). This would lead us to believe that healthcare organizations will likely also have a large increase in racially and ethnically diverse people; however, this is often not the case. In many cases, healthcare organizations have struggled to mirror this shift in their hiring decisions (Futrell & Clemons, 2017). Ideally, healthcare organizations should represent parity with the communities that they serve. One of the goals of corporations, as well as local hospitals, is to help bridge the gap in our society on diversity in the workplace (Futrell & Clemons, 2017).

There is confirming data that shows that a more diverse healthcare workforce could assist in improving healthcare delivery, particularly among underrepresented populations (American College of Physicians, 2010; Institute of Medicine, 2004; Marcelin et al., 2019). Perez-Stable et al. (1998) found that addressing ethnicity and language improved the outcomes of patients. Out of 74 Hispanic patients, 60% were treated by clinicians who also spoke Spanish, and the results showed that having a language-concordant physician

was associated with better healthcare delivery. Reports show that, by 2050, the workforce representation of non-Hispanic whites could decrease by approximately 4% (Toossi, 2006; Myers & Dreachslin, 2007; Pumariega et al., 2005). Finally, in a national survey, Taylor (2015) found that the U.S. population went from approximately 15% racial/ethnic minority in 1960 to 36% in 2010 and has the potential to increase substantially in the future.

Despite the need for diversity in healthcare, there has been limited research done on how current healthcare administrators view racial and ethnic leadership, as well as the perspectives of clinical and administrative personnel in healthcare administration. There have been limited studies that focus on the perspectives of executive leaders on diversity initiatives (Dreachslin et al., 2001; Ng & Sears, 2012). In one such study, nine focus groups were brought together from different racial backgrounds (Dreachslin et al., 2001). Each group answered six central questions on their perspective of racial diversity with healthcare management. Results illustrated the critical nature of the healthcare manager's perceptions of race and diversity through focus groups. Results indicated that healthcare managers did value diversity.

In another study, Ng & Sears and colleagues (2012) found that transformational leadership directly linked to the level of enactment of diversity management processes in the organization. The study observed the impact of CEO personality and leadership behavior concerning organizational diversity and expanded the work of choice theory and how transformational and transactional styles can impact diversity management in organizations. With this limited research available on this topic, it can be argued that there is a gap in the literature illustrating the different perspectives regarding diversity when working in a clinical setting versus non-clinical administrative roles within the healthcare

workplace. In some cases, healthcare leaders are not making adequate changes to ensure their organizations are diverse. Gabor (2008), analyzing employment data, found that 11% of CEOs, 21.5% of health services managers, 43.6% of healthcare support employees, and 63% of housekeepers/maids were individuals form ethnic minorities. This demonstrates that even in organizations that have high levels of diversity, individuals from ethnic minorities are often not equally represented in leadership positions (Saunders Russel & Augustin, 2017).

To provide context and a foundation for diversity within this study, we will focus on cultural intelligence**,** cultural humility, and cultural metrics. Each of these aspects will be discussed within the literature review. The goal of this study is to explore clinical and non-clinical healthcare administrative professionals' perspectives of culture as well as how diversity and culture are addressed within their professional settings.

CHAPTER 2. REVIEW OF LITERATURE

2.1 Introduction

When addressing culture and diversity, there are many terms with similar definitions. Due to all of the overlap of definitions, sometimes healthcare professionals, graduate students, and others interchange them. In order to provide clarity and a foundation for this study, I will define and discuss the important concepts below.

2.2 Diversity

To understand the topic of diversity in healthcare leadership, it is essential to first breakdown the words and their meanings. Diversity has been utilized and defined within a variety of areas over the last 25 years. Gore (2001) defined diversity as:

1. "All characteristics (race, ethnicity, gender, age, religion, disability, and sexual orientation) and experiences that define each of us as individuals" (p.1)
2. Importance of "secondary dimensions of an individual: communication style, work style, organizational role/level, economic status, and geographic origin" (p.1)

Several researchers such as Dreachslin (1998), Kapoor (2011), Kennedy (2009), and Winston 2014) reference Gore's definition in their work. Within this study, I will focus on one aspect of diversity which is race/ethnicity as there is an increasing number of ethnic minority groups within our society who are qualified to work in various healthcare management roles.

Different authors have different opinions on the goals of diversity in the workplace. Winston (2014) thought that diversity's main goal was more about underrepresentation and less about diversifying organizations and increasing services. This view differs from Thomas (1990) who stated that the goal of diversity is not to assimilate minorities into the dominant white male culture but to create a new culture—one that is heterogenous. Kapoor (2011) also agreed with Thomas (1990) on the goal of diversity within organizations. Others like Thomas & Ely (1996) felt that the goal of diversity was not only to change the demographics of an organization but to enhance its function. Even though there is an element of underrepresentation of minority groups in organizations, there is still a need to create or enhance the functions of these organizations. In the present study, Thomas & Ely's (1996) definition will be used to describe and define diversity.

2.2.1 Cultural Humility

Humility, as defined by Davis et al. (2011), is having respect and empathy for someone during a conflict while continuing to be open towards those who have different perspectives, and it requires a person to think and act in integrity with their beliefs, behaviors, and motivations.

Often, cultural humility is another way organizations attempt to measure an employee's understanding of diversity. As literature continues to develop, there has been a shift from using the construct of cultural competence to adopting the construct of cultural humility (Isaacson, 2014). Many authors illustrate cultural humility has the continuous practice of self-awareness, self-reflection, and self-critique through conducting supportive discussions (Allwright et al., 2019; Foronda et al., 2016; Mosher et al., 2017; Saunders Russell & Augustin, 2017). Other authors suggest that cultural humility requires the

individual to take the responsibility of the interactions with others by being an active listener to others who are from diverse backgrounds as well as being attuned to what others are thinking and feeling about other cultures which requires self-reflection and self-awareness (Clark et al., 2011; El-Askari & Walton, 2005; Hook et al., 2013; Isaacson, 2014; Minkler, 2012). Tervalon and Murray-Garcia (1998) define cultural humility as having a lifelong commitment to self-evaluation and critique to help address the power balance and develop mutual benefit with community partners on an individual and group basis.

Davis et al. (2011) defined cultural humility as using the same definition as Hook et al. (2013) which says that openness is closely related to the concept of humility. Davis et al. (2011) categorized humility into two main constructs—one being intrapersonal and the other being interpersonal. Intrapersonal modesty is having a truthful assessment of oneself not being too high or low. Interpersonal modesty is having a facilitate admiration in socially acceptable way especially in public settings. Other studies have measured intrapersonal and interpersonal modesty in how they act in experimental studies (Tice et al., 1995).

2.2.2 Cultural Competence

Fundamentally, cultural competence describes the way an individual perceives the concept of culture – both their own as well as other cultures. For many organizations, cultural competence is looked upon as one way to gauge an employee’s perspective on diversity. Delphin-Rittmon et al. (2013) and Davis (1998) defined cultural competence as the knowledge or understanding of individuals or groups that can be converted into protocol standards and ways to approach other cultures and to expand the quality and

appropriateness of healthcare and health. The National Quality Forum (2008) and Weech-Maldonado et al. (2016) stated the rising capacity of the healthcare system and all constructs within the system should provide diverse patient populations with high standards of care that is patient-centered, evidence-based, and uses an equitable approach. Authors including Calamaro (2008), Cross et al. (1989), and Pumariega et al. (2005) defined cultural competence as a group, system, or agency that uses behaviors, attitudes, and policies to create ways to work successfully knowing the cultural differences that take place.

All of these definitions shed light on what cultural competence is and how it is operationalized within the healthcare field. Ideally developing cultural competence within the workplace can encourage open-mindedness and assist in strategizing how to work with people from diverse backgrounds. However, some researchers critique the construct of cultural competence as it suggests that one can reach mastery or completion when learning about other's cultures (Fisher-Borne et al., 2015; Isaacsion, 2014; Racher & Annis, 2007).

This study will measure cultural intelligence and cultural humility as these constructs have a validated scale that allows self-evaluation by the participants.

2.2.3 Cultural Intelligence

Similar to cultural competence, cultural intelligence also refers to an individual's perspective of culture, and their ability to relate to or work effectively across difference cultures. Cultural intelligence could also be utilized by an organization to try to measure an employee's understanding of diversity and other cultures. Throughout the years, different authors have given their own definitions to cultural intelligence. Livermore (2010) defined cultural intelligence (CQ) as the ability to operate in several ways

surrounding the context of people from different cultural backgrounds including: national, ethnic, organizational, and generational. On the other hand, several authors consider CQ to be the ability to network effectively using skills and traits in different cultural environments (Jyoti & Kour, 2017; MacNab & Worthley, 2012). Other authors defined CQ as the aptitude of a person to work well in situations that are viewed as culturally diverse (Ang & Dyne, 2015; Chen & Lin, 2013; Early & Ang, 2003; Vlajčič et al., 2019). Other authors have given an alternative theory of CQ involving: (1) knowledge, (2) mindfulness and (3) cultural conduct (such as welcome, rituals, etc.) (Solomon & Steyn, 2017; Thomas, 2006; Tuleja, 2014).

Early and Ang (2003) developed a CQ scale from Cultural Intelligence Center (2007) which stated that EQ is a person's capability to successfully work with culturally diverse people. This is the definition of cultural intelligence that will be used in the present study. There are four constructs of CQ: metacognitive, cognitive, motivational, and behavioral. Metacognitive is defined as the ability to direct attention and energy regarding learning about and functioning in situations described by cultural differences. Motivational is defined as the ability to direct focus and energy toward understanding the different situations concerning diverse cultures (Ang et al., 2007; Chen & Lin, 2013). Cognitive is defined as the basic knowledge about an individual culture. Behavioral relates to a person's adaptability in doing verbal and nonverbal actions with people from different cultural backgrounds (Ang et al., 2006; Chen & Lin, 2013). All four of constructs will be discussed in further detail within the theoretical framework section of the paper.

The present study will use the Cultural Intelligence Center's scale to measure the cultural intelligence of clinical and non-clinical administrative professionals are within healthcare administration.

2.3 Theoretical Framework of Cultural Intelligence

The present study uses Ang et al.'s (2006) nomological network and the four components of CQ as the theoretical framework. Nomological network was defined by Trochim, W.M.K (2020) as a representation of the concepts (constructs) of interest in a study, their observable manifestations, and the interrelationships among and between them. Ang et al. (2006) used the nomological network to understand the role of CQ in four main relationships. First, they described the relationship to distal factors such as the big five personality, core self-evaluation, ethnocentrism, need for closure, self-monitoring, demographics, and biographical information. Second, four constructs of CQ affect a host of intermediate or intervening variables such as cross-cultural communication apprehension, anxiety, uncertainty, participation in cultural activities. Third, the likelihood of individual's cognitive ability such as general intelligence, social intelligence, emotional intelligence, and practical intelligence may help predict an individual's outcomes in intercultural situations. The final relationship is the significance of context. Context has the ability to affect the relationship between CQ and intermediate outcomes. In calculating how weak or strong the situational variables are will affect how stronger or weaker the perception of having an intercultural environment and involvement in intercultural activities.

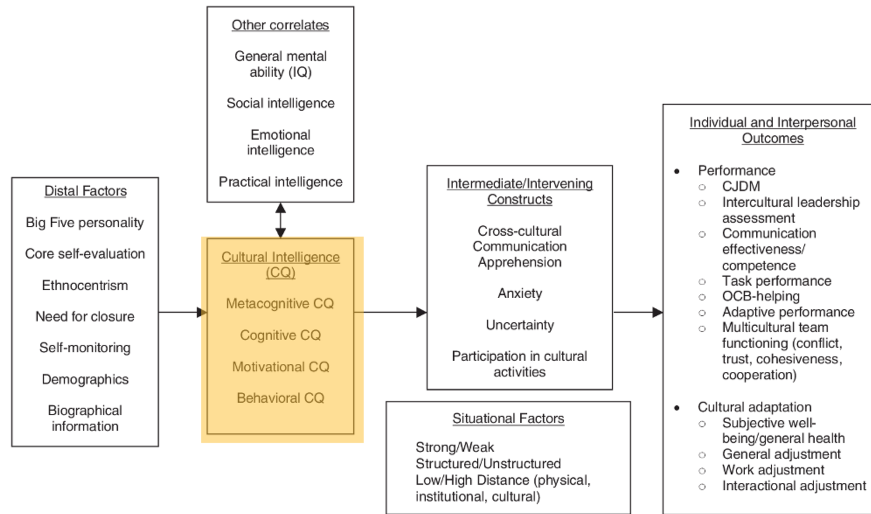


Figure 2.1. Nomological Network Model (Ang et al., 2006).

The four constructs of CQ are metacognitive intelligence, cognitive intelligence, motivational intelligence, and behavioral intelligence. Metacognitive is a person's level of conscious cultural awareness during cross-cultural interactions. Ang et al. (2006) stated that individuals who have strong metacognitive intelligence "question their own cultural assumptions, reflect during interactions and adjust their cultural knowledge when interacting with those from other cultures" (p.20). The major factors for metacognitive intelligence are encouraging active thinking about individuals and settings in diverse cultural backgrounds; sparking engaging challenges to rigid dependence on culturally constrained thinking and norms; and motivating individuals to change their approach so that they are more culturally apt and more likely to carry out the best outcomes in cross-cultural interpersonal relationships.

Ang et al. (2006) described cognitive intelligence as "the knowledge of norms, practices, and conventions in different cultures that has been acquired from educational

and personal experiences" (p.20). The main factors of cognitive intelligence are the knowledge of an individual's level of cultural understanding or the understanding of the cultural environment that they are around. Ang et al. (2006) goes on to define cultural understanding/knowledge as "the knowledge of oneself as embedded in the cultural context of the environment" (p.20). Every society has a fundamental system that is established to provide the basic needs of the people. Some of the fundamental systems within a society are economic systems, social systems, educational systems, systems of communication, systems of supernatural beliefs. The purpose of cognitive intelligence is examining how well a person can understand the fundamental cultural systems of other people.

The third part of CQ is motivational intelligence. Ang et al. (2006) described motivational intelligence as "the capability to direct attention and energy toward learning about and functioning in situations characterized by cultural differences" (p.21). Eccles & Wigfield (2002) discussed the theory of motivation involving two main components: the forecast of knowing that you will complete the task auspiciously and the importance correlated with completing a task. Having strong motivational intelligence helps to ignite intention and vitality toward functioning in appropriate cultural settings.

The final part of CQ is behavioral intelligence. Ang et al. (2006) depicted behavioral intelligence as the ability to demonstrate proper verbal and non-verbal actions when interacting with people from diverse cultures. Understanding the verbal and non-verbal behaviors between people is a critical factor in social interactions. In greeting and meeting different people, one of the best ways to discern someone else's demeanor is by observing their verbal, facial, and outward expressions. There are three ways that Lustig & Koester (1999) discuss behavioral repertories of culture: the range of behavioral enacted;

the display of nonverbal expressions that are used and under what conditions; and in the understandings or significances that are attributed to nonverbal behaviors. People with high behavioral intelligence have the ability to become flexible to the cultures of others and can interact well with diverse groups. Ang et al., (2006) described the behavioral intelligence as a “silent language” because it uses concealed and shrewd ways to interact with people.

2.4 Diversity within Healthcare

Research focusing on healthcare leadership is relatively new. There have been several types of studies that have focused on how executives in healthcare view leadership. For example, one study focused on executives in a focus group wanting to understand their perspectives on racial diversity in healthcare leadership (Dreachslin et al., 2001). Another utilized mailed-out survey methods to examine the leadership style of Canadians whose roles were to increase diversity in their companies (Ng & Sears, 2012). Dreachslin et al. (2000) focused on qualitative focus groups of nursing teams to gather a better understanding of team communication patterns and group demographics for patient-centered care effectiveness. Seeleman et al. (2015) identified domains represented in most healthcare organizations that can be used to create policies that could affect diverse people.

2.5 Diversity within Healthcare Leadership (Administration/Management)

Health administration is defined as the "practice of managing, leading, overseeing, and administering the operation of dynamic, complex health care entities including hospitals, long-term care facilities, health care systems, nursing homes, pharmacies, and health insurance providers" (Capella University, 2017). In 2016, Knorring and colleagues undertook a study to understand how healthcare managers design their managing roles in

relationship to the medical profession within their organizations. This is important because understanding if people see themselves either as a "medical professional" or "non-medical professional" helps to provide a context for how medical professionals view themselves in the workplace – and ultimately may give insight as to the types of professional development and in-services needed within the field. Garman et al. (2010) found that "having graduates with healthcare management programs represented less than 3% of the administrative master's degree graduate for the study period but comprised of 49% of those who became the top administers in one of the ranked hospitals with an overall advantage of 16:1 for graduate programs" (p.95). This study did not collect, nor did it discuss, how their diverse backgrounds may play a role in decisions regarding the who is chosen for administration.

Some researchers suggest that studying diversity in leadership can help to develop theories and resources to help make structural changes in organizations (Eagly & Chin, 2010). There has been a small shift in focus on Academic Medical Centers who started their Diversity Leadership Models to help carry out the new initiatives of their leadership councils (Clapp, 2010). Silver's (2016) focus was on healthcare executives' perspectives on diversity within healthcare leadership. This study focused on cultural competence, therefore the literature should expand to include the constructs of cultural humility and cultural intelligence. The implications from Silver's study will be expanded upon in the present study.

2.6 Cultural Metrics

The five main cultural metrics that will be used for this study are trust, honesty, fairness, a welcoming environment, and organizational culture pertaining to diversity

(Ryberg, 2016; Wagner et al, 2014). These five constructs will be utilized as the foundation for the interview questions and as the referenced categories for the protocol coding. These constructs are used to provide meaning and structure to participant's perceptions regarding culture and diversity within the workplace. Trust is defined by Webster Dictionary as "assured reliance on the character, ability, strength, or truth of someone or something; one in which confidence is placed". Trust opens the door to transparency within an organization or group. Trust can help build working relationships that can increase productivity among staff while also improving morale.

Honesty is defined by Webster Dictionary as "adherence to the facts: sincerity". Honesty is important within the workplace because it can help build a foundation for trusting others. In addition, honesty sets the tone for a work environment of integrity which can promote loyalty in others. Fairness is defined by Lexico Dictionary as "impartial and just treatment or behavior without favoritism or discrimination". Fairness is important within the workplace because it provides an opportunity for employees to achieve to their full potential. A fair organization might cultivate trainings on the standards of an organization. The trainings could discuss the mission, vision, unconscious bias, and opportunities for advancement. A welcoming environment was defined by the Association Forum "as the creation of a sense of belonging and connectedness that engages individuals in an authentic manner in which uniqueness is valued, respected and supported through opportunities and interaction." A welcoming environment strives to allow all people to speak and express their diversity of thought while respecting each individual member of the organization. A welcoming environment can have a positive effect on the productivity of the job and the ability to grow as an organization.

Organizational culture is “the source of motivated and coordinated activities within organizations, activities that serve as a foundation for practices and behaviors that endure because they’re meaningful, have a history of working well, and are likely to continue working in the future.” (Waters, 2004). Pertaining to diversity can be described as initiatives and programing specifically geared toward diversity work. The goal is to create pathways of innovation and examine ways to collaborate with different hospital staff members.

2.7 Purpose & Objectives

Upon a review of the literature, it appears there is little research regarding the perspectives of clinical and non-clinical administrative healthcare professionals and their thoughts on diversity. Therefore, the purpose of this study is to explore departmental culture regarding diversity and inclusion within Kentucky’s Health System.

More specifically, the objectives are as outlined below:

1. Determine a baseline CQ of clinical and non-clinical administrative leaders within Kentucky’s Health System.
2. Explore Kentucky’s Health System leaders’ perceptions of institutional culture regarding diversity and inclusion, through cultural metrics and cultural/diversity programming.

CHAPTER 3. METHODOLOGY

3.1 Introduction

This exploratory mixed-methods study was designed to explore overall cultural perceptions in the workplace of clinical and non-clinical leaders within Kentucky's Health System. This study is important because it explores the different perspectives of clinical and non-clinical administrative groups and how they view diversity within healthcare leadership. By conducting this research, we can explore ways to implement targeted programs on leadership and diversity within the healthcare system.

3.2 Research Design

An exploratory mixed methods design was used which involved a two-step process. Due to the limited amount of research and literature available on this subject, the study was considered exploratory in nature. Hunter et al. (2019) discussed why exploratory methods are a great tool for researching healthcare. They stated the use of this method can help discover a topic that has little literature and allows the participants of the study to add or help expand new knowledge on the topic. First, participants were asked to take the Cultural Intelligence Scale (CQS). This was facilitated through the online platform Qualtrics. The initial email detailed the objective of the study and how to use the link for Qualtrics. The Tailored Design Method was employed to communicate with participants throughout the process (Dillman et al., 2014). Participants were requested to take the CQS scale via email to be completed and returned within 21 days. A reminder email was sent once every week to encourage participation. Clinical and non-clinical administrative staff had a four-week window to receive reminders about the survey via email. The final email gave a 24-hour

period for the participants to have access to complete the survey. Incentives were used to encourage participation, and five participants were randomly selected to receive a $50 gift card.

Once they completed the assessment, they were asked if they would like to participate in a semi-structured interview. For the second part of the study, a researcher developed, semi-structed interview was done via phone. Each interview was recorded and lasted approximated 40 minutes. Interviews were transcribed and coded for themes. In order to maintain confidentiality, aliases were created and linked with each participant. All research was undertaken upon obtaining IRB approval.

3.3 Study Population

Participants from two different Kentucky hospitals volunteered to participate in this study; one was a southern rural mental health hospital, and the other was an urban state hospital. Study participants came from two different groups – clinical administrators and non-clinical administrators. Clinical administrators are defined as those who have face to face interactions with patients and give examinations, treatments, or continued care. An example of clinical administrators are doctors, nurse practitioners, or psychiatrists. Whereas, non-clinical administrators are defined as those who may interact face to face with patients but, they do not give continued patient care or treatment. Examples of non-clinical administrators would be human resource managers, financial managers, and IT specialists. The only requirement to volunteers for this study was being 18 years or older and being a clinical or non-clinical administrator. Access to this population was obtained through an executive employee at one of the hospitals.

The overall study response rate was 22.22% (14/63) for the CQS. There were 14 individuals who participated in the Cultural Intelligence Scale out of a total of 63 people who were sent the initial invitation email. 28.5% of the volunteers completing the Cultural Intelligence Scale were males, 62.2% were females, and 7.14% were non-binary. Fifty percent of the participant populations ranged from ages 35-44. The majority of the population had 6 to 15 years of healthcare experience (54.14%). The range was within 0.86 of each of the seven points on the Likert Scale.

3.4 Study Instruments

3.4.1 Cultural Intelligence Scale

This study was conducted in two phases: cultural intelligence scale and semi-structured interviews. Cultural Intelligence Scale (Ang et al., 2015) determines the perceived cultural intelligence of each individual. The scale consists of 4 constructs: metacognitive, cognitive, motivational, and behavioral. The scale is comprised of 20 questions, with five questions each addressing the previously mentioned constructs. Participants responded using a Likert Scale ranging from 1 to 7; where 1 represents "strongly disagree" and 7 represents "strongly agree".

The scale was examined for both validity and reliability in the Ang's previous work with the constructs. Reliability for the Cultural Intelligence Scale was determined through Cronbach's alpha from Ang's original study that has been used in 1,000s of research studies at the Cultural Intelligence Center (α); alphas for each constructs are as follows: metacognitive CQ = 0.59, cognitive CQ = 0.88, motivational CQ = 0.84, and behavioral CQ = 0.91 (Ang et al., 2015). According to Nunnally and Bernstein (1994), alphas greater

than or equal to 0.70 suggest acceptable reliability along with factor loadings that exceed 0.50.

Discriminant validity was also addressed and ensures that the measures used within a scale does not highly correlate with other measures from which it is supposed to differ (Sureshchandar et al., 2002). According to Ang et al., (2006) it is demonstrated that the four constructs of CQ were related to, but distinct from, the Big Five personality traits in conceptually meaningful ways. In another study, Templer et al., (2006) examined motivational CQ and demonstrated that it predicted adjustment of global professionals, beyond realistic job and living conditions previews. These two studies are noteworthy because they provide initial evidence of the discriminant validity and practical significance of CQ (p. 336).

3.4.2 Semi-Structured Interview Protocol

The researcher-designed interview protocol consisted of eight questions based on cultural metrics and individual perceptions of leadership within the workplace. An expert panel comprised of individuals working in the healthcare field, with experience in healthcare management, reviewed the interview protocol for content and face validity. All panel experts received documentation on the purpose, objectives, literature review, and interview questions. The experts were asked to review clarity, verbiage, and the applicability to their specific disciplines. Modifications were integrated into the interview protocol based on the panelist's recommendations to improve the interview questions.

Trustworthiness and credibility were determined in the qualitative inquiry in several ways. Interviews were transcribed and coded using the cultural metrics. The last step was done using the member check strategy to send participants feedback data,

analytical categories, interpretations, and conclusions. This strengthens the data by having participants and the researcher analyze the same material. Confirmability was established by the audit trail strategy giving transparent descriptions of the steps taken throughout the research process. Finally, the researcher examined their own bias, world lens, values, perceptions, and how they were a part of the research decisions throughout the entire interview process (Korstjens & Moser, 2017).

3.5 Role of Researcher

One of the unique aspects of qualitative research is the role that the researcher has in the instrument for collecting data. Creswell (2014) discussed how the researcher's "personal background, culture, and experiences hold potential for shaping their interpretations, such as the themes they advance and the meaning they ascribe to the data" (p. 186). Creswell also suggested that humans operate and provide their own clarity through past history, social, and cultural viewpoints. The researcher contacted the 'gatekeeper' to gain access to the hospital administrative population (both clinical and non-clinical). I had the responsibility to safeguard participants and the data collected. I was responsible for sending out initial emails for the Cultural Intelligence Scale and also calling to interview participants. It is critical to understand that I was involved in both the Cultural Intelligence Scale population and interview population. I acknowledge that I have inherent biases within the entire process including interviews, analysis, and conclusions.

3.6 Researcher Perceptivity

In an attempt to be transparent, it is important to describe the researcher's background. I am an African American woman, born in South Carolina, and grew up in

several states. I have worked in the healthcare system from being a certified pharmacy technician to previously being a Patient Access Specialist within the hospital settings. I have a Bachelor of Science degree in Public Health from a Kentucky school of higher education. As an undergraduate student, I had the opportunity to intern with KentuckyOne Hospital's Chief Diversity Officer for one semester, focusing on patient care and patient assessments. From my perspective, my background in healthcare and public health gives me a solid foundation from which to approach this study.

3.7 Data Analysis

The Cultural Intelligence Scale comprises 20-scaled items covering Earley and Ang's (2003) four constructs of CQ: metacognitive, cognitive, motivational, and behavioral. Each item on the scale ranged from 1 to 7 on a Likert Scale rating, with a response of 1 "strongly disagree" and 7 "strongly agree".

Data were collected, coded, and analyzed for themes. Interviews were transcribed word for word using NVivo Software. Then the data was protocol coded occurring to the cultural metrics. Sixteen sub themes emerged from the data analysis. To provide added clarity the 16 sub themes were divided into clinical and non-clinical.

Saldaña (2016) defined protocol coding as a "generally comprehensive list of codes and categories provided to the researcher that is applied to the data collection" (p.175). This technique was used for the cultural metrics as the category and codes of trust, honesty, fairness, welcoming environment, organizational culture pertaining to diversity. The second category focused on coded themes that used the axial coding technique. Once the transcription was complete for each interview key words from the cultural metrics were highlighted with different colors. Then the quotes were examined for subtheme topics that

explained what the interviewee wanted to discussed. It was noticed that they there was commonalities with the subthemes. They were slightly different depending on if they were clinical or non-clinical.

3.8 Limitations

There are several limitations to this study. First of all, this study was created to address departments within two hospitals within the state of Kentucky. Since the study was exploratory, the intent was to begin a discussion on how culture is viewed in departments within healthcare institutions. Still, the results can be used as a foundation for further research and discussion, but the results seen here may not be generalizable beyond the study population.

In addition, there was a small response rate within both stages of the study. The small sample size could possibly be attributed to COVID restrictions, state government guidelines on social distancing, and the lack of ability to visit the hospitals' offices to talk directly with participants. Often, contacting participants only through electronic mediums limits the ability to explain the study and appeal to one's motivation to participate. It is for all of these reasons that the researcher believes participation was limited within the study.

A final limitation of this study is the way in which participants decided to identify themselves. The findings for this study were based on self-reported answers to the assessment and interviews. Furthermore, it was up to the participants to identify themselves as clinical or non-clinical administrators as well as their race, age, and gender. As each of these aspects are due to self-identification, there could be slight differences in perception from participants on similar constructs.

CHAPTER 4. RESULTS

4.1 Introduction

In this chapter, I will present results from the Cultural Intelligence Scale, as well as describe the results of the semi-structured interviews. The overall purpose of this research study is to describe the perspectives of clinical and non-clinical administrative regarding the cultural environment in their workplace.

4.2 Demographics

A total of fourteen clinical and non-clinical individuals participated in the study. Basic demographics were collected in order to provide a deeper and more accurate description of study participants. Specific demographics are illustrated in Tables 4.1 – 4.4 as outlined below:

Table 4.1. Study Participant Gender Identity

Gender	Clinical	Non-Clinical	Total
Male	2	2	4
Female	7	2	9
Non-Binary	1	0	1
Total	10	4	14

In general, a majority of study participants reported being female (n = 9), while four identified as male, and one participant identified as non-binary. Breaking this down according to professional role, there were two males from a clinical background (14.28%), and two from a non-clinical background (14.28%). Seven females were from a clinical setting (50%), while two females identified as non-clinical (14.28%). The non-binary participant came from a clinical setting.

Table 4.2. Study Participant Age

Age	Clinical	Non-Clinical	Total
25-34	1	1	2
35-44	5	2	7
45-54	2	0	2
55-64	2	1	3
Total	10	4	14

Regarding the age of study participants, the majority of participants were 35 – 44 years old (n=7), with five of these participants being from a clinical (35.7%) background and two being from a non-clinical (14.28%) background. A few participants fell into older categories, with two clinical participants identifying as 45 – 54 years old, and three participants identifying in the 55 – 64 years old category. In this final category, two of the participants were clinical and one was non-clinical. Finally, one clinical and one non-clinical participant identified as being 25-34 years old.

Table 4.3. Racial Background

Racial Background	Clinical	Non-Clinical	Total
White Caucasian	9	3	12
Black or African American	1	1	2
Total	10	4	14

A lack of diversity was clearly illustrated when looking into participant racial background. A majority of participants identified as White Caucasian (n =12); from these 12 participants, three were non-clinical (21%) and nine were clinical (64%). Only two participants identified as Black or African American (n=2); among these two participants, one came from a clinical (7%) background and one came from a non-clinical (7%) background.

Table 4.4. Years of Experience Working in a Hospital Setting

Years of Experience	Clinical	Non-Clinical	Total
5 years or less	1	2	3
6-10 years	3	1	4
11-15 years	3	1	4
16-20 years	1	0	1
26-30 years	2	0	2
Total	10	4	14

When analyzing years of experience, a majority of participants indicated they had 15 years or less experience working in a hospital setting. More specifically, three clinical (21.4%) and one non-clinical (7.14%) participants indicated they had been working in a hospital setting for 11 to 15 years. In addition, four other participants (28.6%) indicated they had 6 to 10 years of experience, with three participants (21.4%) being clinical and one being non-clinical (7.14%) in this category. Finally, three participants (21.4%) indicated they had 5 years of experience or less in working in a hospital setting, with one clinical (7.14%) and two non-clinical (14.28%) participants identifying in this category.

From a demographic perspective, these results mirror similar patterns as other studies like Weech-Maldonado et al. (2016) and Dreachslin et al. (2001) with the majority of participants identifying as White Caucasian women with at least 10 years of experience in the field. Second example. Ultimately, these demographics seem to suggest that there is limited diversity in both the clinical and non-clinical aspects of hospital administration, which may have implications for leadership and practice within these spaces.

Research Objective 1. Determine a baseline CQ of clinical and administrative leaders within the Kentucky's Healthcare system

4.3 Cultural Intelligence Scale Analysis

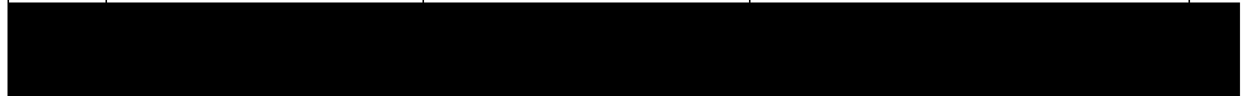
For the first step of this study, participants were asked to take the CQ scale assessment. This assessment illustrates individual perceived intelligence when relating within intercultural environments and activities. The participant response rate for this stage was 22.22% (14/63); more specifically, 14 individuals chose to take the Cultural Intelligence Scale, out of a total of 63 individuals identified as potential study participants.

Table 4.5 shows the mean score for each question on the Cultural Intelligence Scale. Scores were averaged and based upon a 7-point Likert scale; standard deviations and overall construct means were also calculated and presented above. Statistics for each construct are outlined in the paragraphs below.

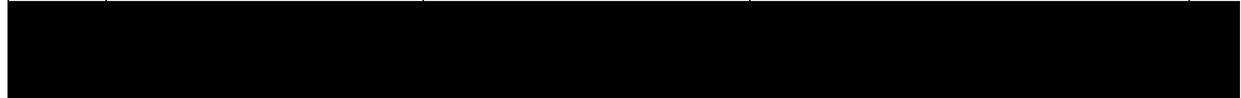
Table 4.5 Cultural Intelligence (CQ) Scale Assessment Results (n=14)

	Cultural Intelligence Scale Results						
	Questions	Clinical			Non-Clinical		
		Mean	Range	SD	Mean	Range	SD
MC1	I am conscious of the cultural knowledge I use when interacting with people with different cultural backgrounds	6.3	5-7	0.67	6	5-7	0.82
MC2	I adjust my cultural knowledge as I interact with people from a culture that is unfamiliar to me.	5.9	5-7	0.74	6	5-7	0.82
MC3	I am conscious of the cultural knowledge I apply to cross-cultural interactions.	5.78	5-7	0.67	5.75	5-6	0.5
MC4	I check the accuracy of my cultural knowledge as I interact with people from different cultures.	5.4	3-7	1.17	4.25	3-5	0.96

	Metacognitive Total Average	5.85			5.5		



	Questions	Clinical			Non-Clinical		
		Mean	Range	SD	Mean	Range	SD
COG1	I know the legal and economic systems of other cultures.	4.2	2-5	1.14	3	2-5	0
COG2	I know the rules (e.g., vocabulary, grammar) of other languages.	3.22	1-5	1.3	3.33	1-6	2.52
COG3	I know the cultural values and religious beliefs of other cultures.	4.5	1-6	1.51	4.5	2-6	1.73
COG4	I know the marriage systems of other cultures.	3.9	1-5	1.45	3.75	2-6	2.06
COG5	I know the arts and crafts of other cultures.	4.2	1-6	1.48	3.25	1-6	2.22
COG6	I know the rules for expressing nonverbal behaviors in other cultures. - COG 6	4.2	1-6	1.48	3.25	1-6	2.22
	Cognitive Total Average	4.05			3.52		



	Questions	Clinical			Non-Clinical		
		Mean	Range	SD	Mean	Range	SD
MOT1	I enjoy interacting with people from different cultures.	6.6	6-7	0.7	6.75	6-7	0.5
MOT2	I am confident that I can socialize with locals in a culture that is unfamiliar to me.	4.7	3-7	1.25	4.75	3-7	1.71
MOT3	I am sure I can deal with the stresses of adjusting to a culture that is new to me.	4.8	3-6	0.92	4.5	2-7	2.38
MOT4	I enjoy living in cultures that are unfamiliar to me.	4.3	2-7	1.83	4.5	3-7	1.73
MOT5	I am confident that I can get accustomed to the shopping conditions in a different culture.	4.6	2-6	1.43	4.5	3-7	2.38
	Motivational Total Average	5			5		

	Questions	Clinical			Non-Clinical		
		Mean	Range	SD	Mean	Range	SD
BEH1	I change my verbal behavior (e.g., accent, tone) when a cross-cultural interaction requires it.	4.1	2-6	1.52	4.5	2-7	2.08
BEH2	I use pause and silence differently to suit different cross-cultural situations.	4.1	2-5	1.2	3.75	1-6	2.22
BEH3	I vary the rate of my speaking when a cross-cultural situation requires it.	4.7	2-6	1.34	5.75	5-6	0.5
BEH4	I change my nonverbal behavior when a cross-cultural situation requires it.	4.8	2-6	1.62	5	3-7	1.63
BEH5	I alter my facial expressions when a cross-cultural interaction requires it.	4.6	2-6	1.35	4.25	2-6	1.71
	Behavioral Total Average	4.46			4.65		

Note: [a] *Participants responded utilizing a Likert scale as follows: 1= strongly disagree , 2 = disagree, 3 = somewhat disagree, 4 = neither agree or disagree, 5 = somewhat agree, 6 = agree, 7 = strongly agree*

Table 4.5 depicts the range results in the Likert CQ Scale. They were calculated based on the 7 points within the scale. The ranges helps to determine where on the Likert scale each question falls. The range of numbers that participants answered the lowest the highest number answered for each question. An example is Behavioral CQ construct in question 2: *I use pause and silence differently to suit different cross-cultural situations.* The mean of non-clinical administrators was 3.75 which could mean that people somewhat agreed. However, in examining the range of the question it could fall into between 1 and 6. This could show the reader there was a wide range of answers to some of the questions, and this could impact the overall averages.

Metacognitive CQ is a person's level of conscious cultural awareness during cross-cultural interactions. There were four questions measuring this construct. Overall, clinical

and non-clinical administrators responded very similarly - the average mean for all four questions (within the construct) was 5.85 for clinical participants and 5.5 for non-clinical. In reference to the Likert scale, this might means that both groups somewhat agreed with the Metacognitive CQ questions. Practically, this could suggests participants perceived themselves have a relatively high Metacognitive CQ, which indicates they believe they see themselves as being pretty culturally aware when engaging in cross-cultural interactions.

Cognitive CQ is the knowledge of an individual's level of cultural understanding or the understanding of the cultural environment that they are most familiar with at a given time. There were six questions asked within this construct. While not statically significant there were some differences between the means of clinical and non-clinical participants. For three questions - *I know the legal and economic systems of other cultures, I know the arts and crafts of other cultures, I know the rules for expressing nonverbal behaviors in other cultures-* the means varied significantly. For each of these questions the mean for clinical participants was a strong neutral (Likert of 4), while non-clinical participants had a mean of 3-3.25 , which means they somewhat disagreed. In examining the ranages were from 1 to 6 so the mid-ranage average could be based on a bimodal sample in which half could be from the low ranage and the other from the upper ranage. This could show the reader there was a wide ranage of answers to some of the questions. Looking at overall average of this construct you can see that clinical participants are neutral 4.05 on feeling like they might understand cognitive intelligence while non-clinical feel like they don't understand and feel like they aren't sure of other cultures.

Motivational CQ is the capacity to steer the focus and efforts towards learning and operating in environments where those cultures are different from your own. There were

five questions within this construct. Within the motivational construct, the questions had similar mean scores between clinical and non-clinical administrators. Clinical and non-clinical administrators overall total average was 5. For question one - I *enjoy interacting with people from different cultures this was a strong response by the participant on both sides*. They might like to interact with people but they might not confident. It seems like they want to interact but there may seem to be a contradiction in being able to interact with them based on neutral scores of questions two through five.

Behavioral CQ is the ability to understand the verbal and non-verbal behaviors between people, which are a critical factor in social interactions. There were five questions asked within the construct. Clinical administrators mean score was 4.46 and for non-clinical administrators 4.65, this may reveal that between the two groups they were very similar in scores overall. Based on the Likert scale used, the data might reveal a neutral disposition to understanding the non-verbal and verbal behavior of unfamiliar cultures. However, in examining the ranages were from 1 to 6 so the mid-ranage average could be based on a bimodal sample in which half could be from the low ranage and the other from the upper ranage. This could show the reader there was a wide ranage of answers to some of the questions. A few of the aspects with the construct that might be neutral in three questions - *I use pause and silence differently to suit different cross-cultural situations, I vary the rate of my speaking when a cross-cultural situation requires it, I change my nonverbal behavior when a cross-cultural situation requires it*. Overall, it may seem different in the average but in the questions we can see a little deeper difference between them.

In summary, in most cases the four constructs, had similar overall mean scores between clinical and non-clinical administrators. There was a deviation within the questions themselves. In looking more deeply at the Cognitive CQ, Motivational CQ and Behavioral CQ different perceptions were expressed by clinical and non-clinical participants at the individual question level. Overall, this means that the majority of participants are either neutral or somewhat agree to being somewhat competent on the four constructs of the cultural metrics. The participants may or may not feel extremely confident on all of the questions asked but they don't feel like they failed in understanding other cultures that are not their own.

In order to add some depth of knowledge of individual perceptions of the CQS, individuals participating in the semi-structured interviews were asked about their thoughts as to their results of the CQ Scale. Overall, participants felt their results were accurate and weren't surprised by the results. There were different perceptions about the scale Max, a non-clinical interviewee, stated that "…they didn't feel threatened by the survey; it was eye opening". Lilly, a clinical interviewee felt that she met the qualification for each constructs. Lilly stated, "…I believe I'm pretty good at recognizing the areas that I don't know. I'm sure that I have a blind spot but whenever I looked at the questions, I was pretty frequently able to say, yeah, I don't know that. Yes, I do know that." These quotes illustrated that this survey was not difficult or stressful. Clinical and non-clinical administrators within this survey felt they understood what was being asked of them and felt free to respond honestly.

Research Objective 2: Explore Kentucky's Healthcare leaders' perceptions of institutional culture regarding diversity and inclusion, through cultural metrics and cultural/diversity programming.

4.4 Semi-Structured Interview Analysis

The second part of this study focused on gathering more in-depth data from participants through a semi-structured interview. Six out of 14 participants (42.9%) agreed to participate in the 40-minute-long interviews, which were held via phone (due to COVID protocols). Two were non-clinical and four were clinical administrators who participated in the semi-structured interviews. The semi-structured interview was guided utilizing a researcher-designed interview protocol. An expert panel comprised of individuals working in the healthcare field, with experience in healthcare management, reviewed the interview protocol. The questions were designed based on the cultural metrics and the feedback of the expert panel (See Appendix 1).

Interviews were recorded, transcribed using the NVivo Software, then coded using protocol coding. Saldaña (2016) defines protocol coding as a "generally comprehensive list of codes and categories provided to the researcher that is applied to the data collection" (p.175). This technique was applied using the cultural metrics as the list of codes trust, honesty, fairness, welcoming environment and organizational cultural pertaining to diversity. These categories were already established through the cultural metrics. While going through the coding process, 16 sub-themes emerged from the data. All of these sub-themes are described below. Finally, within the established primary categories, the sub-themes are further broken down according to clinical and non-clinical perspectives.

4.4.1 Trust

Webster Dictionary defines trust as “assured reliance on the character, ability, strength, or truth of someone or something; one in which confidence is placed”. In interviewing participants, it was clear that there was a lack of trust that stemmed from the feeling of not having transparency about the hospital. Several of the participants did discuss that there were examples of how the hospital tried to work towards being transparent and ways to help address the issue. It was concerning that there was at least one person in each group that expressed that they did not trust an aspect of executive administration, or they felt that the staff could not trust the head of leadership. In addition, it was apparent that non-clinical participant focused more on teamwork and creativity, whereas clinical participants focused on creating bonds and having administrators committed to patient care as well as staff care.

The most efficient and reliable healthcare teams have ascertained an ultimate attribute, TRUST! Trust is important in healthcare because it provides a connection between the leadership and the frontline workers. Trust sets the stage for a foundation of a cohesive and effective working environment. Trust within healthcare is crucial in achieving patient centered care. Trust is the assurance that the leaders are focused on making decisions that promote the best interest of staff and the organization.

There were three sub-themes that emerged during the analysis and one related to clinical care: Building Trust Fuels Communication, Commitment to Patient Care & Staff, and Transparency Through Detailed Communication. One sub-theme was identified when speaking with non-clinical participants: Transparency in Communication Empowers Teamwork & Creativity.

4.4.1.1 Clinical: Building Trust Fuels Communication

The clinical administrators believed that you cannot have trust without developing proper communication. This means that from senior management to the frontline staffer there should be two-way communication so that staffers are able to talk openly to senior management, which would build trust throughout the organization. When employees are treated with kindness and respect, it helps create a stronger bond within the organization. Paul stated, “trust is one of those things where leadership has to trust the staff to do the work. The most important piece is the people who are doing the work (staffers) have to trust that the administration has their back.” When leadership displays actions of respect and appreciation for the accomplishments of the staff. Staff then may find it easier to trust the administration. Bonding can also occur when company deficiencies are addressed and improved by dedicated members of the staff.

4.4.1.2 Clinical: Commitment to Patient Care & Staff

Commitment to Patient Care and Staff promotes an environmental trust. When staff are able to perform their duties efficiently, overall patient care will improve. Mary said, “I feel like trust does develop around the commitment to patient care. I think that people (staff/administrators) who are able to focus on the vulnerability of our populations, lean on each other and support one another in what is fundamentally a difficult job”. Commitment comes with an innate desire between leadership and staff to perform dugites at the highest level of performance. Thus, the creditability of the organization increases.

4.4.1.3 Clinical: Transparency Through Detailed Communication

Transparency is not only communicating information to the staff and other leaders but how the staff perceives the information it is given. The perception is employees may feel as though they are not receiving all the information. Sometimes the lack of transparency can give a false sense of honest communication within organization. Mary said she "...feels like they're trying to hide things or that they don't want us to look closely at things and we're being discouraged. It feels dishonest."

4.4.1.4 Non-Clinical: Transparency in Communication Empowers Teamwork & Creativity

Sarah viewed transparency differently. She stated "... I don't feel like there isn't trust and I think we are really open with the budget." She considers transparency to be a budgetary perspective versus others who viewed it from an interpersonal relationship point of view. Max a non-clinical administrators shared: "Trust comes from a long-term understanding of one another and teamwork which is encouraged through emphasizing teamwork with creative things. Such as different types of commissions. We also have our leadership teams, which are transparent in many decisions that are being made, and those are communicated quickly and effectively, as well as a rationale for why decisions were made."

The goal is to empower the team to inhabit teamwork and communication skills. When staff are able to see the transparency within the organization through policy, there is a freedom to become more creative and innovative in the work environment. The absents of transparency may cause a low morale in the workplace.

4.4.2 Honesty

Honesty is defined by Webster's Dictionary as "adherence to the facts". While conducting the interviews, the majority of the interviewee's felt that trust and honesty go hand and hand. There were a few who felt that the administration did an average job of communicating the information necessary to complete their job efficiently. However, there were others who felt that the hospital kept missing the mark. Many interviewees felt that if they did not feel honesty within the hospital it does impact how they give care to others and how they interact with other employees.

Honesty and integrity cultivates a dependable, trustworthy, and loyal staff. Honesty can be applied to both sides of the spectrum, leadership and staff. Ultimately, honesty helps to foster a positive working climate within healthcare.

Three sub themes were identified during the analysis and one from the clinical perspective: Attempts Change but Misses Target. Among non-clinical administrator interviews, two sub-themes were identified: Transparency in Communication Between Departments & Staff and Recognizing Mistakes and Making Improvements.

4.4.2.1 Clinical: Attempts Change but Misses Target

Clinical administrators felt as though there were avenues to seek out ways to address the issues within the hospitals. Most believe that the hospital tried to create ways to resolve difficult topics. The issue is not in having a system to address the problems, the issue is how or if the problems will be addressed and resolved. Nyllah said "...when things are bad as well as good you just don't pull together a town hall meeting just to talk about the raises that everybody's getting, you actually pull them together to talk to them about the tough and difficult things." In essences honesty is admitting the need for improvement

in all areas, including leadership. Addressing topics that are crucial to staff development and positive work climate.

4.4.2.2 Non-Clinical: Transparency in Communication Between Departments & Staff

This subtheme is distinguished from other subthemes due to the viewpoint of the non-clinical perspective. The viewpoint of the non-clinical administrator is targeted to the individual staff within the departments. Whereas a clinical administrator focuses on overall hospital needs not just in one area but the entire hospital. Effective communication requires all parties to display the hospital's mission, vision and values within the organization. When departments or individuals feel as though they are excluded from making hospitals policies, a break of honesty can occur within the whole team. It is the responsibility of the healthcare administration to embrace the fundamental openness of being transparent. Max stated that "...we have the element of transparency between different departments and especially with administrative staff."

4.4.2.3 Non-Clinical: Recognizing Uncertainty and Making Improvements

As administrators and staff members, it is important for anyone working in the organization to acknowledge when an error has occurred. The acknowledgment and resolution of errors builds the strength of any organization. Healthcare leads very little room of error because you are dealing with human life so protocols must be in place to ensure consistency. Max felt that having the insight to be vulnerable enough to say, "I do not know everything, but what I do know I will share with the team." One example that Sarah gave was "...when COVID-19 started a lot of information was unknown about the virus last year. A lot of misinformation was out there. But what the organization did quite

well was saying things like, "we don't know exactly what we're getting ourselves into, but this is what we anticipate is going to happen. And these are the steps that we've taken in anticipation. ...but at the same time, the administration is not 100 percent perfect…"

4.4.3 Fairness

Fairness is defined by Lexico Dictionary as "impartial and just treatment or behavior without favoritism or discrimination." Showing the same treatment to all employees is an important aspect from the interviews. There was a sense for those who were in non-clinical settings that they believed there were places to air their concerns. Some discussed surveys but a few discussed the need for training reform. Some clinical administrators felt that even given the opportunity to voice the problems regarding fairness, they still see treatment between staff an administrators as unfair and that no one is really listening.

Employees want to know that no one is showed favoritism or considered more important than another employee. It is the obligation of the leadership to create policies that reflect an atmosphere of fairness. Each year the guidelines should be reviewed and amended to accommodate the needs of the organization. Two sub themes emerged during the analysis and one was clinical: Lack of Fairness and one was non-clinical: Satisfaction Survey/Reports Based on Trainings from Staff.

4.4.3.1 Clinical: Lack of Fairness

It is crucial when teams are established to have an outlet or framework that any individual can go to and express their concerns. No matter what level or educational background within the hospital, all employees are important and their concerns should be considered. When concern is not heard it impacts the morale and productivity. Paul stated

that “there's a strong disparity in how employees are treated based on their level of education and role within the hospital and just by that nature alone, it tends to be a very intentional racial disparity. And I don't think it's fair.” The interviewee for this quote did not feel comfortable giving an in-depth explanation as to how or why they felt equities occur within the hospital.

4.4.3.2 Non-Clinical: Satisfaction Survey/Reports Based on Trainings from Staff

Training is a tool to help build the staff's skill level to become proficient in their jobs. Hospitals are required to conduct patient satisfaction surveys, as well as reports on the performance of the staff. These reports can give insight to what improvements should be taken to enhance the hospital's satisfaction process. Staff development is essential to building a sustainable workforce. Max said “if a manager sends the report, you know, the issues pertaining to the unit or individual’s problems; then we as leaders create an action plan where we think improvements can be created.

4.4.4 Welcoming Environment

A welcoming environment is defined by the Association Forum “as the creation of a sense of belonging and connectedness that engages individuals in an authentic manner in which uniqueness is valued, respected and supported through opportunities and interaction.” The participants had differing ways to interpret welcoming environment. Some saw it as physical space while others saw it as workplace culture. More of the non-clinical interviewees discussed the physical aspects of a welcoming environment and described the building and how they feel it makes a difference in the cultural of the hospital. Clinical interviewees saw a welcoming environment as kind interactions with

other staff. As a whole, having a pleasant working environment is an important aspect within hospital culture.

Non-clinical and clinical interpretations can be used to filter a comfortable setting for healthcare. Adding structural and personal aspects of a welcoming hospital is easily obtained. It requires a visionary eye to enhance the structure of the building. Moreover, all employees should have training to expand their customer service skills. There were three sub themes that emerged during the analysis and two were clinical: Gaps & Solutions for a Welcoming and Job Position Determines How the Administration Interacts with Staff. Non-clinical has one sub theme: Building a Friendly and Positive Work Physical Environment.

4.4.4.1 Clinical: Gaps & Solutions for a Welcoming Environment

Making staff feel welcome in the workplace is subjective. When conducting these interviews, participants shared that they worked in a friendly and open hospital. One difficult part of describing the hospital workspace is explaining empirical ways that employees exhibit friendliness to others and their patients. Lilly stated "...the staff are friendly. they're kind to one another, they're willing to step out, help out, and answer questions." In order to arrive at an ideal open and friendly workplace, employees might buy into the idea of creating cohesive working relationships.

Paul stated that "…It's such a large institution. And there are periods in places where it's pretty fragmented. …I think that's an area where we could probably do better just because it's so large and there's so many required things they (staff) have to do and be a part of. I think we take the approach of like a checklist kind of approach instead of saying things like what would give meaning to this new employee, what would make them feel

welcome? Would it be, you know, meeting with all of their work people up front so they can at least get a glimpse of who those persons are? Because so oftentimes new employees, they won't even see where they're working or know where they're working or even be able to sniff out the work that they'll be doing until because all these different class stuff." Finding the hidden gaps and creating solutions is a way to change the work culture to a more welcoming environment.

4.4.4.2 Clinical: Job Position Determines How the Administration Interacts with Staff.

Sometimes staff members are treated differently according to their title or position at the hospital. This is does not correlate with a welcoming environment, but it can show how others feel when new employees join the workforce. When staff feel that certain positions are more important than others it could cause high turnover rates because people want to feel welcomed and valued for the work they bring to the organization.

Lilly stated that they "...believe that our hospital is very welcoming of higher-level staff, so the new doctor coming on board, I believe, is treated very well. However, if someone is at a lower level of direct patient care I think a lot of times they receive the perception that if you don't like it here, you can leave, and we can hire someone else."

4.4.4.3 Non-Clinical: Building a Friendly and Positive Work Physical Environment

An inviting and friendly workplace may be easy to achieve. A workplace that is open and bright can create a positive work environment. When an employee's attitude towards their physical environment is enthusiastic, this could increase morale within the hospitals. Surroundings that are bright and cheery and staff that is engaging brings an array of harmony to the hospital. Max stated "... (the building) has all windows and all of the

patients have a window in their room and a bathroom in their room. The dining room overlooks an atrium. So, it's very physically welcoming. When you walk in the front door the employees are friendly and say hello to you." This creates a friendly and positive workplace.

4.4.5 Organizational Culture Pertaining to Diversity

Diversity within this study will focus on racial and ethnic diversity. Thomas & Ely (1996) felt that the objective of diversity was not only to change the demographics of an organization but to enhance its function. Questions about diversity were important in showcasing the different experiences participants have which may help to help inform hospital decisions. Within the interviews, all were asked to define diversity. They all were asked to reflect upon the importance of diversity in clinical administrators and how this may impact patient care. Others who are non-clinical did seem satisfied with the level of diversity with the organization though diversity does not equate to equity or inclusion.

A diverse workforce can create a path for innovation. Collaboration with diverse cultures make exceptional hospital teams. It is the duty of administrators to ensure that they bring to the table as many different kinds of people as possible to meet an objective. There is confirming data that shows that a more diverse healthcare workforce could assist in improving healthcare delivery, particularly among underrepresented populations (Marcelin et al. 2019). There were three sub-themes that emerged during the analysis and two were clinical: How Diversity is Defined and Diversity Involves Equity & Inclusion. In the analysis of non-clinical administrator interviews, one sub-theme was identified: How People Define Diversity.

4.4.5.1 Clinical: How Diversity is Defined

The meaning of diversity may be defined differently depending upon who is providing the definition. Diversity can be linked to personal experiences. Even though diversity has been defined by multiple people it is important to set a standard of how leaders within the hospital define diversity. Confirming that every employee understands how diversity applies to them. Paul said "I see diversity as being how we look, because I think that's the easy part of diversity. I think diversity also concerns those displaying viewpoints and ideals of race, ethnicity, sexual orientation, and gender. They all need a comfortable space as individuals to be a part of decision making."

4.4.5.2 Clinical: Diversity Involves Equity and Inclusion

Equity requires organizations to treat all employees in a fair manner. Inclusion dictates that every employee can participate and contribute. Some organizational structures in a hospital solely address diversity and not equity nor inclusion. Equity within a hospital is social justice. Equity is ensuring that those who need extra support or resources receive them compared to employees who do not need them to become efficient at their job. Highlighting this view, Mary shared, "The problem I see with people who come into a role as a Diversity Officer, tend to be consumed with only "climbing the ladder". I think that people who are more grassroots and more connected to lower-level workers are much more in tune with the issues of labor and inequity than people who are most concerned by job promotions, "ladder climbing".

4.4.5.3 Non-Clinical: How People Define Diversity

Thomas & Ely (1996) said that the purpose of diversity is not only to change the demographics of an organization but also to enhance its function. The non-clinical administrators shared a similar view. Diversity takes the experiences and thoughts of others

to help to create new ways of approaching situations. Paul said “...diversity is...having different representations of a population within segments or having a variety of opinions, ideas, world views coming together.

4.4.5.4 Non-Clinical: Enhance Visible Aspects of Diversity in Staff & Administration

When hospitals can observe and recognize the differences in others, work environments may become more inclusive. Using a one dimensional viewpoint limits the organization's spectrum, and the hospital may lose the value of having three or more viewpoints to assist in the solution to a particular problem. Those who have already established a career in administration and those who want to be future leaders look to see themselves in those leaders who are established in their careers. It incentivizes future administrators to join in that career path.

Most people want to see visual representations of themselves. Patients want a staff that is diverse enough to be able to enhance the language barriers that could affect their medical health. Max stated “...the visibility of diversity and the leadership in terms of ethno-cultural diversity is quite lacking.” The challenge with that is if you want to encourage the future generations, mentor people, then organizations will have to increase their ability to enhance diversity.

Table 4.6 CQ Constructs in Relationship with Interview Subthemes

CQ Constructs in Relationship with Interview Subthemes	
Four Constructs	**Sub Themes**
Metacognitive	Job Position Determines How the Administration Interacts with Staff
	Commitment to Patient Care & Staff
Cognitive	N/A
Motivational	Gaps & Solutions for a Welcoming Environment
Behavioral	Building Trust Fuels Communication
	Transparency Through Detailed Communication
	Transparency in Communication Empowers Teamwork & Creativity
	Transparency in Communication Between Departments & Staff
	Building a Friendly & Positive Work Physical Environment

4.5 Cultural Intelligence Constructs in Relationship with Interview Subthemes

The cultural metrics is composed of 5 categories: trust, honesty, fairness, welcoming environment and organizational cultural pertaining to diversity. Webster Dictionary defines trust as "assured reliance on the character, ability, strength, or truth of someone or something; one in which confidence is placed". Honesty is defined by Webster's Dictionary as "adherence to the facts. Fairness is defined by Lexico Dictionary as "impartial and just treatment or behavior without favoritism or discrimination." A welcoming environment is defined by the Association Forum as "the creation of a sense of belonging and connectedness that engages individuals in an authentic manner in which uniqueness is valued, respected and supported through opportunities and interaction." Thomas & Ely (1996) felt that the objective of diversity was not only to change the

demographics of an organization but to enhance its function. In order to bridge the discussion of the assessment (quanatative) and the semi-structure interviews (qualitative) together, table 4.6 was created to show how using the Ang's theory of the four constructs of CQ, conntects to the five components of the cultural metrics. Out of a total of 16 subthemes, there seems to be 8 subthemes that connected within the constructs. In examining the questions from the CQ Scale and the definitions of the four constructs were used to determined if the subthemes fit with the constructs. Metacognitive CQ is a person's level of conscious cultural awareness during cross-cultural interactions. There were two sub themes identified within the metacognitive CQ: Job Position Determines How the Administration Interacts with Staff and Commitment to Patient Care & Staff. Upon analyzes no subthemes within the study seemed to fall within the cognitive CQ construct. Cognitive CQ is the knowledge of an individual's level of cultural understanding or the understanding of the cultural environment that they are most familiar with at a given time. Motivational CQ is the capacity to steer the focus and efforts towards learning and operating in environments where those cultures are different from your own. Motivational CQ had one subtheme: Gaps & Solutions for a Welcoming Environment which fit within the construct. Behavioral CQ is the ability to understand the verbal and non-verbal behaviors between people; this is a critical factor in social interactions. There were five subthemes that connected to the behavioral CQ construct: Building Trust Fuels Communication, Transparency Through Detailed Communication, Transparency in Communication Empowers Teamwork & Creativity, Transparency in Communication Between Departments & Staff, and Building a Friendly & Positive Work Physical Environment. The reasoning for selecting the connection between constructs and

subthemes was based on the CQ Scale question key phrases or words paired to the conversation topic of the subtheme or had to do with the type of interactions people have together. The data dictated the constructs and subthemes due to the quotes of interviewees and the topics that they discussed within each interview. An example of interviewee's answers to the questions that might reveal an association to the construct is the conversation with Max about *Transparency in Communication Empowers Teamwork & Creativity.* In this conversation, Max states "Trust comes from a long-term understanding of one another and teamwork which is encouraged through emphasizing teamwork with creative things, such as different types of commissions. We also have our leadership teams, which are transparent in many decisions that are being made, and those are communicated quickly and effectively, as well as a rationale for why decisions were made." The behavioral CQ relates to understanding non-verbal and verbal communication which Max demonstrated the importance of trust and how it relates to communicating with your team. In examining the table, it appears to be more subthemes in the behavior CQ than the other constructs. This may be due to the study healthcare. One of the focuses that could caused more subthemes in behavioral could be due to the focus that healthcare emphasizes the behaviors of others. This illustrates how people view their cultural intelligence within a healthcare setting. This could possibly impact how we interact with people (i.e., patients, staff, employees).

4.6 Leadership in Healthcare

In order to gain a perspective of participants regarding leadership within their workplaces, two interview questions were asked regarding leadership. The first was: *Are there changes that you think should be taken to improve diversity in healthcare*

management? If so, what are these actions? This question was vital because it helped us to understand how significant these participants felt diversity is to their everyday life. This question requires an example of diversity in action. It is important to comprehend if participants felt that we have already made enough changes that they feel comfortable as things stand. These type of thoughts can show a lack of growth or understanding of what improvements need to take within healthcare leadership and how to implement them. Overall participants like Mike said "…And I'm stumped on that one…our current staff is diverse." Compared to Lilly who stated "I think so many people some people cringe to hear some of this, but I believe it. I know that if we wait for people to if we wait for people, including leaders to. Wait until they can see their own bias, then you and I are going to never see the changes we need to see."

The second question was: *As we move into the future, how do you think the growing diversity in the United States will affect healthcare management?* Within any type of organizational culture, leadership is an essential aspect. The second question examines the future of healthcare management. As stated within the Literature Review the demographics are going to be changing within US population. It is necessary that we ask our leaders within healthcare and how will the hospital industry adapt to these change?

Listening to the interviews there was a clear understanding that yes leadership did need to grow. However, in several conversations few people knew how to affect the change that they wanted to see. Moving forward, having spaces to explore diversity within healthcare leadership can help guide those who don't feel included within the process access to part of the solution. All of the participants realized that change is not going to

happen overnight, but it takes those who see the issues within the organization to mention them to their leaders.

Overall, most of the participants within this study knew the definition of cultural intelligence. Mary, a clinical administrator, stated "cultural intelligence as the ability to adapt to new information, to take what we know about different cultures, people who are different and diverse trauma, and connect to them to the application of all of the information we already have, as well as the willingness to gather important and relevant information. So, I think it's a combination of both information, curiosity and adaptability." Max stated that cultural intelligence is being "…aware of other's cultures using any knowledge I would have in helping to interact with them ….and maybe understanding their behavior or their gestures." These two questions can open the exploration on this topic to where we go from here and how we can enrich the acceptance of diversity.

CHAPTER 5. Conclusions, Implications & Recommendations

5.1 Conclusions

The purpose for this study was to explore the topic of culture and diversity within healthcare leadership. The goal was to gather some understanding on how healthcare administrators view their own Cultural Intelligence (CQ), as well as how culture and diversity are operationalized within the healthcare workplace. Understanding a baseline for CQ and perspectives around culture in the workplace would assist administrators in understanding what is working well, and where improvement is needed. A discussion on these topics could help Kentucky's Health System and other health systems as a whole, to address parity within the workplace (especially in association with administrative positions).

As was mentioned in the introduction, the United States demographics continue to become more and more diverse. The U.S. population is estimated to increase from 319 million to more than 400 million by 2051 (Colby & Ortman, 2014; Myers & Dreachslin, 2007), with nearly 1 in 5 Americans estimated to be foreign-born by 2060 (Colby & Ortman, 2014; Myers & Dreachslin, 2007; Saunders Russell & Augustin, 2017). Clearly, to keep up with the ever-diversifying population, healthcare organizations may need to increase their racial and ethnically diverse employee base; often that is not the case. In many cases, healthcare organizations do not mirror this shift and may not hire an ethnically diverse staff in their organizations (Futrell & Clemons, 2017). Over the last 20 years, there continues to be a shift in the demographics in the United States. The U.S. population is estimated to increase from 319 million to more than 400 million by 2051 (Colby & Ortman, 2014; Myers & Dreachslin, 2007), with nearly 1 in 5 Americans estimated to be foreign-

born by 2060 (Colby & Ortman, 2014; Myers & Dreachslin, 2007; Saunders Russell & Augustin, 2017). Healthcare organizations need to increase their racial and ethnically diverse people by 29%. In many cases, healthcare organizations do not mirror this shift and may not hire an ethnically diverse staff in their organizations (Futrell & Clemons, 2017). Hospital staffers serve everyone no matter their race, creed, gender, and age or any other identity. It helps to have staff that come from similar backgrounds, cultures and identities to give the best possible service to the patients that they encounter.

However, the way diversity is defined and viewed in society will determine one's perspective. It is apparent from this study that both clinical and non-clinical administrators have some understanding of aspects such as cultural humility, cultural competence or cultural intelligence. It is important to understand how healthcare leadership conceptualizes these different concepts, as this can assist is providing a structure to develop appropriate organizational structures, provide clarity to different aspects within the organization's culture, and finally assist in creating applicable professional development opportunities for employees.

One take away from this study on the topic of diversity is that however you define diversity and identify as an individual, will determine your perspective and what you expect as a leader within healthcare. Even with different definitions of diversity, there were three ways scholars assessed someone's knowledge of diversity; cultural humility, cultural competence, or cultural intelligence.

This study did highlight the CQS scale and semi-structure interviews even though most participants believed they had knowledge and protocol standards such as the pillars for their hospitals that encompasses how they approach patients and each other.

When considering the CQS results, it seems that participants are interested in engaging within individuals from diverse cultures, and participating in cultures varying from their own, but may not be comfortable doing so, or understand how to effectively engage. This hesitancy could have a variety of impacts on the workplace culture.

The results from the CQS scale, provided clinical administrators with little opinion on social aspects of other cultures while non-clinical felt like they don't understand other social aspects of other cultures. It seems like they want to interact but there does seem to be a contradiction in being able to interact with them based on neutral scores of questions two through five. Overall, participants may not feel extremely confident on all of the questions asked but they don't feel like they failed in understanding other cultures that are not their own.

The interviews also add to this picture of healthcare diversity and culture. Trust sets the stage for a foundation of a cohesive and effective working environment. Trust within healthcare is crucial in achieving patient centered care. Trust is the assurance that the leaders are focused on making decisions that promote the best interest of staff and the organization. When employees are treated with kindness and respect, it helps create a stronger bond within the organization.

Honesty and integrity cultivates a dependable, trustworthy, and loyal staff. Honesty can be applied to both sides of the spectrum, leadership and staff. Ultimately, honesty helps to foster a positive working climate within healthcare. As administrators and staff members, it is important for anyone working in the organization to acknowledge when an error has occurred. The acknowledgment and resolution of errors builds the strength of any organization.

Similarly, fairness was seen as an important aspect within the organization's workplace. Employees want to know that no one is showed favoritism or considered more important than another employee. When concerns are not heard, it impacts the morale and productivity of the work environment. Training is a tool to help build the staff's skill level to become proficient in their jobs. Staff development is essential to building a sustainable workforce.

The participants had differing ways to interpret welcoming environment. Some saw it as physical space while others saw it as workplace culture. Making staff feel welcome in the workplace is subjective. In order to arrive at an ideal open and friendly workplace, employees must buy into the idea of creating cohesive working relationships.

A diverse workforce can create a path for innovation. Collaboration with diverse cultures make exceptional hospital teams. The meaning of diversity may be defined differently depending upon who is providing the definition. Equity requires organizations to treat all employees in a fair manner. Inclusion dictates that every employee can participate and contribute.

Diversity is an action word. It is important to comprehend if participants felt that we have already made enough changes that they feel comfortable as things stand. It is necessary that we ask our leaders within healthcare, how will the hospital industry adapt to these changes?

Diversity and culture research is a fairly new topic of study, especially in the healthcare area. Understanding the nuances of how leadership views their own cultural intelligence, as well as how culture and diversity are valued and demonstrated within the organizational culture. This is an important first step in understanding this topic. The study

only gives a small glimpse into the topic, of diversity in healthcare. Ultimately, as society continues to expand and diversify, it is the responsibility of healthcare leadership to make adequate changes to ensure their organizations are diverse. It is only with the vision and support of healthcare leadership that future organizational cultures within the healthcare industry can begin to shift towards being more diverse and valuing unique and diverse cultures within the workplace.

Understanding that there is much more to uncover regarding culture and diversity in the workplace, there are many different research projects that could be undertaken in the future. New research is important to continue to understand the impact that diversity within healthcare has on hospital culture. Future study could examine the differences between how front-line staff with no administrative role view diversity compared to their administrators. Another study discussing how clinical and non-clinical leadership view their protocols on diversity compared to the patients that take care of during their stay. Important research can include extending this study to other hospitals in this area, as well as in other areas around the United States.

Another aspect of future study could also focus on non-administrative employees that work for healthcare leaders. It could be important to gain a deeper understanding of their perspectives to evaluate if non-administrative employees are similar or different from their leadership team members which could also help gain the holistic perspectives of diversity from all employees at a hospital.

5.2 Implications & Recommendations

It was mentioned that increased communication transparency could encourage building trust in the organization. Therefore, healthcare administrators could practice

communication transparency (when appropriate) so that employees feel they know what's going on in the organization. This builds trust and can encourage buy-in with employees. The goal is to empower the team to inhabit teamwork and communication skills.

Non-Clinical interviews mentioned that enhancing visible aspects of diversity within the workplace could assist in helping to diversify the culture. This may be an important consideration when trying to diversify our healthcare organizational cultures. This could be as basic as adding multicultural art to common spaces, or as involved as adding diversity to your hiring practices, but this an important consideration when shifting cultures to mirror a more diverse workplace.

Overall, one recommendation from what was learned as part of this study was that when staff do not feel as though they are being treated fairly confidence is lost from the administrator no matter if its clinical or non-clinical. If faith or confidence is lost the morale and productivity is low in the workplace. A suggestion as to how to improve fairness is to create programs and specific ways staff can address their issues with administration. The process could have open access or "open door policy" with confidentiality in mind.

A work environment that is conducive to productivity creates a high retention of employees and more importantly patient satisfaction. Many people can view a welcoming environment differently such as physical space or the coworkers in a department. IT is important that uniformity is used for patients but also staff. The uniformity could be how a person is greeted, protocols on best practices of communication and a person's layout of immediate workspace.

Every organization has a different way of defining diversity. Depending on the leader, diversity might not be important in their outlook for the future of the organization. It is essential to have a well-balanced team in discussing diversity issues. Organizations should strive not only to be diverse but to incorporate equity in how the vision is implemented throughout various departments.

All in all, the journey of diversity is vast, complex, challenging, but can also be very rewarding work. As we look to the future, I ask you as I did the participants for this study, what type of impact can diversity make on healthcare? When I reflect on this study, I ask myself what kind of impact can I make in this field? Diversity is an important part of the foundation necessary for workplace success and productivity. I encourage everyone to reflect and assess their communication with others from different cultural backgrounds during their day-to-day interactions.

The ending observational concepts indicate that there is more work to be done in the area of diversity within healthcare leadership. Diversity initiatives are difficult subjects to discuss within most organizations especially healthcare. Discovering new strategies and interactions can produce the changes necessary for diversity to be positively impactful. Such as including in-service cultural knowledge courses for all employees annually. This training could not only be beneficial to new hires but also those who already work for the hospital. The training should be geared to educating everyone on different biases of culture, gender, and other identities. Then creating safe confidential programs that can stimulate honest conversations about diversity, inclusion and equity. In the research of professor Dreachslin, J. L. (1998) who used focus groups in race, sex, gender and class. She used six different focus groups to obtain an understanding of how

they felt about certain topics related to diversity. When using focus groups after strong educational classes instructors can examine and point out themes that can be used to change the culture within the hospital for the better.

As we make positive strides in the area of diversity, this could increase a welcoming hospital climate, staff productivity, and the rate of recidivism may decrease. Greater diversity can help with the implicit biases of staff and management. Diverse hiring practices of clinical and non-clinical staff is one of the goals in moving leadership forward.

APPENDICES

Appendix 1: Interview Script

Before we begin the interview, we will go over the cover to ensure that you understand the content of the cover letter, have the opportunity to ask questions prior to proceeding and then you can provide your verbal consent.

Interview Questions (to be completed after the CQ scale is taken with those who gave consent):

1. How would you define cultural intelligence?
2. We have just discussed your CQ test results.
    a. What are your thoughts?
    b. Did you find what you expected? Why or why not?

The next few questions will focus on different aspects of organizational culture. I would ask that you answer these questions in reference to your perception of the organizational culture of your hospital:

3. Could you please describe the vision/mission statement of your hospital?
    a. How is the vision/mission demonstrated in the organization?
4. Do you feel that trust is encouraged within the organizational culture?
    a. If so, how? If not, why not?
5. Do you feel that honesty is demonstrated within the organizational culture of your hospital?
    a. If so, how? If not, why not?
    b. Could you provide an example supporting your answer?

6. Do you feel that people (i.e., patients and employees) are treated fairly in your hospital?
    a. What would be the impact of having a diverse leadership team in healthcare?
    b. Who would be most impacted by having diverse leadership teams?
    c. Where do you see diversity addressed in your hospital (this could be specific examples of where you see it demonstrated)?
7. Are there changes that you think should be taken to improve diversity in healthcare management? If so, what are these actions?
8. As we move into the future, how do you think the growing diversity in the United States will affect healthcare management?

Appendix 2: Coding Guide for Interviews

Coding Guide				
Trust	Honesty	Fairness	Welcoming Environment	Organizational Cultural Pertaining to Diversity

Appendix 3: Survey Questions

Perspectives of Healthcare Workers on Leadership

Survey Flow

Standard: Directions (1 Question)
Block: CQ (20 Questions)
Standard: Demographics (7 Questions)

End Survey:

Page Break

Start of Block: Directions

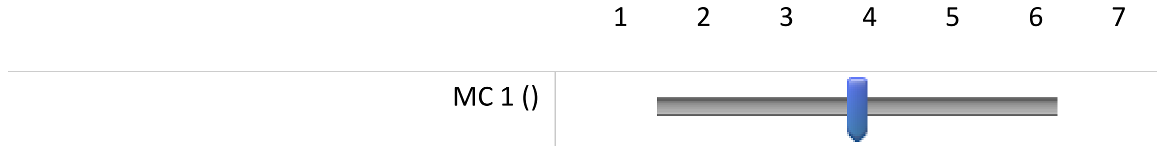
Instructions There is confirming data from the American College of Physicians (2010) that shows that a more diverse healthcare workforce could assist in improving healthcare delivery, particularly underrepresented populations. Despite the need for diversity in healthcare, there has limited research done on how current healthcare administrators view racial and ethnic leadership, as well as the perspectives of clinical and administrative leaders in healthcare administration. Researchers at the University of Kentucky are inviting you to take part in a survey about your perceptions of institutional culture regarding diversity and inclusion, through cultural metrics and cultural/diversity programming. If you volunteer to take part in this study, you will be one of 200 people to do so. The survey will take less than 30 minutes to complete. There are no known risks to participating in this study. Read each statement and select the response that best describes your capabilities. Select the answer that BEST describes you AS YOU REALLY ARE (1 = strongly disagree; 2 = disagree; 3 = somewhat disagree; 4 = Neither agree or disagree; 5 = somewhat agree; 6 = agree; 7 = strongly agree)

End of Block: Directions

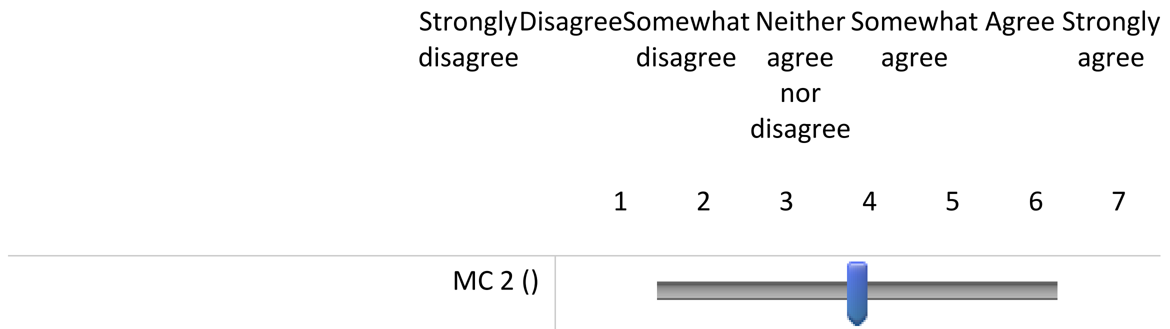
Start of Block: CQ

Q1 I am I am conscious of the cultural knowledge I use when interacting with people with different cultural backgrounds.

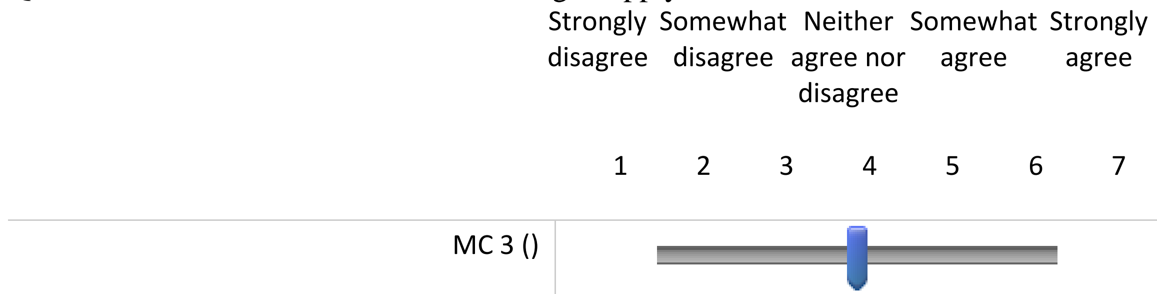
Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree



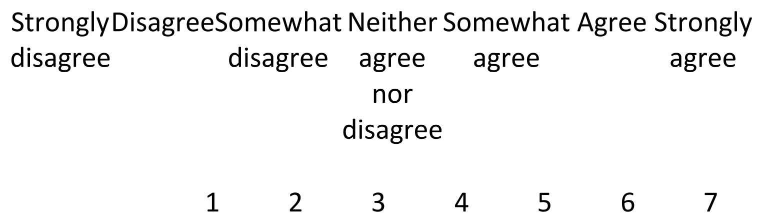
Q2 I adjust my cultural knowledge as I interact with people from a culture that is unfamiliar to me.



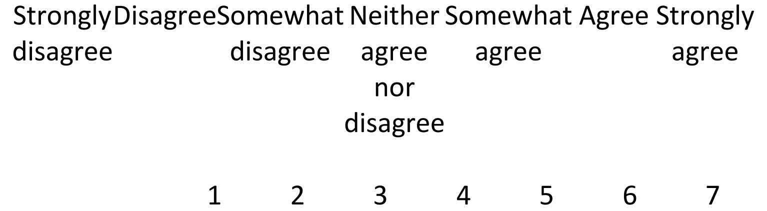
Q3 I am conscious of the cultural knowledge I apply to cross-cultural interactions.



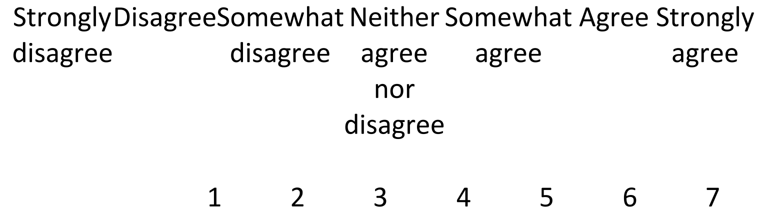
Q4 I check the accuracy of my cultural knowledge as I interact with people from different cultures.



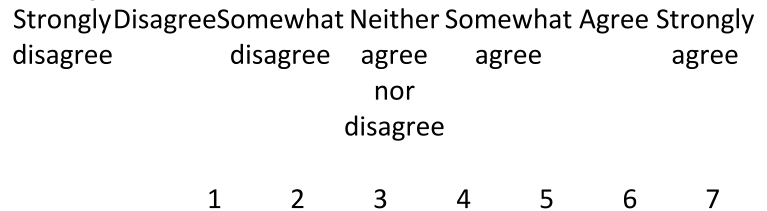
Q5 I know the legal and economic systems of other cultures.



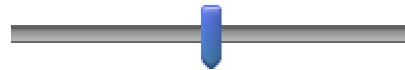
Q6 I know the rules (e.g., vocabulary, grammar) of other languages.



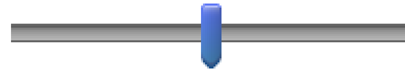
Q7 I know the cultural values and religious beliefs of other cultures.



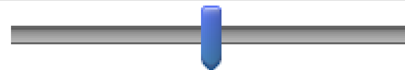
Q8 I know the marriage systems of other cultures.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
COG 4 ()							

Q9 I know the arts and crafts of other cultures.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
COG 5 ()							

Q10 I know the rules for expressing nonverbal behaviors in other cultures.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
COG 6 ()							

Q11 I enjoy interacting with people from different cultures.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
MOT 1 ()							

Q12 I am confident that I can socialize with locals in a culture that is unfamiliar to me.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
MOT 2 ()							

Q13 I am sure I can deal with the stresses of adjusting to a culture that is new to me.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
MOT 3 ()							

Q14 I enjoy living in cultures that are unfamiliar to me.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
MOT 4 ()							

Q15 I am confident that I can get accustomed to the shopping conditions in a different culture.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
MOT 5 ()							

Q16 I change my verbal behavior (e.g., accent, tone) when a cross-cultural interaction requires it.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
BEH 1 ()							

Q17 I use pause and silence differently to suit different cross-cultural situations.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
BEH 2 ()							

Q18 I vary the rate of my speaking when a cross-cultural situation requires it.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
BEH 3 ()							

Q19 I change my nonverbal behavior when a cross-cultural situation requires it.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
BEH 4 ()							

Q20 I alter my facial expressions when a cross-cultural interaction requires it.

	Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
	1	2	3	4	5	6	7
BEH 5 ()							

End of Block: CQ

Start of Block: Demographics

Q21 Gender:

- ◯ Male (1)
- ◯ Female (2)
- ◯ Non-Binary (3)
- ◯ Transgender (4)
- ◯ Prefer not to say (5)

Q22 Age:

- 19 - 24 (1)
- 25 - 34 (2)
- 35 - 44 (3)
- 45 - 54 (4)
- 55 - 64 (5)
- 65 - 74 (6)
- 75 or older (7)

Q23 Racial Background:

- White (1)
- Black or African American (2)
- American Indian or Alaska Native (3)
- Asian (4)
- Latino/x (5)
- Multiracial (6)
- Choice Not to Answer (7)

Q24 Year(s) Worked at the Hospital/ Tenure:

- 5 years or less (1)
- 6-10 years (2)
- 11-15 years (3)
- 16-20 years (4)
- 21-25 years (5)
- 26-30 years (6)
- 31 years or more (7)

Q25 Which type of healthcare administrator you?

- Clinical Administrator (1)
- Non-Clinical Administrator (2)

Q26 Would you be interested in participating in an interview and being contacted by the Researcher?

- No (1)
- Yes (2)

Carry Forward Selected Choices from "Q26"

Q27 Please provide an email address to be contacted.

____

End of Block: Demographics

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VITA

Katherine Alexandria Counts

EDUCATION

University of Kentucky — Expected: May 2020
Master of Science in Community and Leadership Development

University of Louisville — May 2017
Bachelor of Science in Public Health & Minor in Communications

WORK EXPERIENCE

University of Kentucky: College of Agriculture, Food & Environment *Department of Community & Leadership Development, Research Assistant* — 2019-Present

University of Kentucky Hospital — 2018- 2019
Patient Access Services Representative

AmeriCorps- Winburn Middle School — 2017- 2018
AmeriCorps Member, Lexington, KY

Kentucky One Health — Jan 2017- April 2017
Internship with VP of Diversity and Inclusion, Louisville, KY

University of Louisville — Jan 2016 – May 2016
School of Medical Department of Infectious Disease
Research Assistant

University of Louisville — Jan 2015- May 2015
J.B School of Engineering Department of Bioengineering
Research Assistant

PRESENTATIONS, PUBLICATIONS, AND POSTERS

Conducted a Poster Presentation at the Southern Rural Sociological Association Meeting — February 2020

Co-authored an Oral Presentation at the Southern Rural Sociological Association Meeting — February 2021