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Walden University

College of Management and Technology

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Michael Le

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2021

Abstract

Health Care Leader Strategies for Cultural Diversity in the Workplace

by

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Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

December 2021

Abstract

Health care leaders who lack strategies to manage workers from diverse ethnic and cultural backgrounds face high employee turnover. High employee turnover can jeopardize the health of patients and the financial stability of their organization. Grounded in the cognitive diversity theory, the purpose of this qualitative multiple case study was to explore strategies eight health care leaders in Iowa use to manage diverse employees. Data sources were semistructured interviews, researcher notes, and a review of the diversity policies of each facility. Five themes identified through thematic analysis included leaders using recruitment strategies to promote diversity, leaders encouraging and using communication/feedback, leaders conducting diversity training to encourage diversity, leaders providing suitable working conditions to promote diversity, and leaders encouraging and engaging in teamwork and collaboration. A key recommendation for health care leaders is to conduct diversity training that encourages teamwork and collaboration amongst employees with diverse cultures and backgrounds. The implications for positive social change include the potential for health care leaders to build a more inclusive culture that can lead to lower turnover in staff and improve the quality of healthcare for patients.

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Dedication

To my father and mother's memory for always supporting, helping, and standing by me. In addition, to my wife, Minh, and my children, Tom and Kaylyn, whose love, inspiration, wisdom, and encouragement have enriched my life in ways I would never have dreamed possible.

Acknowledgments

I would like to take this opportunity to express my special thanks and appreciation to Dr. Marilyn K. Simon for mentoring and encouraging me in my work and for allowing me to grow as a researcher. I also would like to thank Dr. Annie H. Brown for serving on my dissertation committee. Finally, yet importantly, I offer a special thanks to my wife, my children, and all of my friends for being so supportive throughout my academic journey.

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Section 1: Foundation of the Study

Promoting equality and respecting diversity in the health care field ensure that people value other people and have the same access to all opportunities. Hospitals and health care systems administrations and managers emphasize delivering care tailored to the needs of their diverse patient populations. The diversity disparity in health care facilities is a concern in the U.S. medical management system (Cizmas et al., 2020). Hospitals and health care systems are working to diversify their executive team, board of directors, and staff to best serve diverse customer segments (Cletus et al., 2018). Many hospital teams foster diverse and inclusive communities to involve all staff and deliver high quality and equal care to every patient. Fulfilling demands from diverse patient segments will be paramount as the health care industry transitions from a volume-based to a value-based delivery structure (J. M. Jones & Dovidio, 2018).

Problem Statement

Globalization has led to an increase in the number of employees who are ethnic and racial minorities and an increase in cultural barriers such as speaking different languages and holding different cultural beliefs, despite the implementation of national and transnational policy interventions to address these issues (A. Jones et al., 2021; Malik et al., 2018). Lacey et al. (2018) estimated that between the years 2016 and 2026, 39 million people would enter the U.S. labor market, and that population would largely consist of ethnically and racially diverse groups. The general problem was that the complexity of a racially and ethnically diverse workforce can adversely affect an organization’s performance. The specific problem was that the leaders of some health

care organizations lack adequate strategies to manage workers from diverse ethnic and cultural backgrounds to increase performance.

Purpose Statement

The purpose of this multiple case study was to explore strategies that leaders of health care organizations use to manage workers from diverse ethnic and cultural backgrounds to increase performance. Eight health care professionals, managers, and administrators in the state of Iowa who had been successful managing a culturally and ethnically diverse workforce served as participants in the study. Applying or adapting strategies that other leaders have used to manage cultural diversity in health care organizations may have positive implications. Cultural diversity can improve productivity levels, increase creativity, and provide a beneficial social change to the communities involved (Inegbedion et al., 2020). The health care facilities in the previous study were those providing and receiving health care from a culturally diverse organization.

Nature of the Study

The three most common research methods are qualitative, quantitative, and mixed (R. B. Johnson & Christensen, 2020). I used the qualitative research method for this study. Researchers use the qualitative method to explore participants' experiences and views related to phenomena. The quantitative method was not appropriate for this study because quantitative researchers seek to examine variables' characteristics or relationships using numerical data to generalize from a sample (see Creswell & Creswell, 2018). Mixed-methods researchers collect, analyze, and use quantitative and qualitative methods (Venkatesh et al., 2016). Quantitative and mixed-methods research were not

appropriate for the current study because both methods require analyzing data and using hypothesis testing to examine relationships between variables, which did not align with the intent of this study or my research question.

The design of this qualitative research was a multiple case study. Researchers use a multiple case study design to compare results regarding a phenomenon from multiple organizations (Creswell & Creswell, 2018). I considered other qualitative designs, including ethnography, grounded theory, and phenomenology. An ethnographic researcher studies an intact cultural group using observation and interviews, which was unsuitable for the study because I did not be explore cultural constructs. Grounded theory leads to the construction of theories and hypotheses after collecting and analyzing data (Glaser, 2016), which did not align with the intent of the current study. I also considered the phenomenological design in which researchers identify the essence of human experiences and narrative studies for exploring the lives of individuals through their personal stories (see Creswell & Creswell, 2018). I did not need to explore the personal meanings of participants' lived experiences in this study. A multiple case study was expected to be more suitable than a single case study because, as noted by Yin (2018), a single case study does not provide an opportunity for comparison among varying conditions across different organizations.

Research Question

What strategies do leaders of health care organizations use to manage culturally diverse workers and therefore increase performance?

Interview Questions

1. What strategies do you use to recruit workers from different ethnic and cultural backgrounds?
2. What strategies do you use to ensure that you obtain multiple perspectives from your employees?
3. What strategies do you use to manage employees who present diverse problem-solving recommendations?
4. What strategies do you use to manage employees with viewpoints based on different social and cultural contexts who fail to understand each other properly?
5. Based on your experience, how have your strategies to manage cultural diversity affected your organization's bottom line?
6. What else can you share with me about your organization's strategies for cultural diversity to increase performance?

Conceptual Framework

The conceptual framework that guided this study was cognitive diversity theory (see Amabile et al., 1994). This theory offers unique perspectives on the variety of ways leaders and managers think and solve problems. According to cognitive diversity theory, a diverse workforce allows multiple perspectives stemming from the cultural differences among groups or organizational members, and results in creative problem-solving and innovation. A culturally diverse workforce increases the opportunity to strengthen the attainment of goals by providing input from people who think differently. Leaders of

organizations can unintentionally create cultural barriers that restrict the degree of cognitive diversity through their recruitment process (Mello & Rentsch, 2015). These biases include demographic distinctions such as race or gender, as well as worldviews (Mello & Rentsch, 2015). Colleagues tend to gravitate toward people who think and express themselves in similar ways. As a result, groupthink often occurs in organizations. When this happens, the result is functional bias and low cognitive diversity that can negatively affect an organization's performance (Meissner & Wulf, 2017).

Researchers who use the cognitive diversity theory can understand team practices, activities, and leadership efforts to promote diversity and teams' productivity (Mello & Rentsch, 2015). A critical understanding of this theory is important to derive conclusions and make recommendations to improve productivity. Researchers can use cognitive diversity theory to explain and analyze the implications of effective management and human resource practices, such as cross-cultural training, on diversity to increase employees' productivity (Bender & Beller, 2016). I expected cognitive diversity theory to facilitate identifying, understanding, and analyzing strategies that health care organizational leaders use to support teams and improve individual employees' performance.

Operational Definitions

Cognitive diversity: Cognitive diversity refers to the inclusion of individuals with different viewpoints informed by their diverse cultural backgrounds, gender, race, sex, and religious identities and experiences, which they apply within the work environment and solve problems through cognitive exploration models (Pöyhönen, 2017).

Cultural barriers: Cultural barriers refer to the cross-cultural communication challenges faced in an organization when employees use different languages, gestures, behaviors, and symbols in their communication (Lott & Abendroth, 2019). People come from different cultural backgrounds with specific approaches that people from other backgrounds can misinterpret or misunderstand, thereby causing a cultural barrier (Midgley et al., 2017).

Cultural diversity: Cultural diversity refers to the recognition, respect, appreciation, and acknowledgment accorded to people of different cultures within an organization that encourage and celebrate the differences and create a harmonious and productive workplace (Dover et al., 2019; Grigoryan & Schwartz, 2020).

Diverse workforce: Diverse workforce refers to differences among employees of an organization based on race, gender, age, ethnicity, sexual orientation, religion, social class, academic level, and mental and physical condition (Bogilovic et al., 2020). A diverse workforce can encompass how people identify themselves and others within the workplace (Bogilovic et al., 2020).

Qualitative research: The focus of qualitative research is collecting nonnumerical data through interviews, questionnaires, firsthand observations, and open-ended communication to analyze concepts and experiences and formulate an original idea (Gaus, 2017; Queirós et al., 2017).

Transnational policy: A transnational policy refers to a policy that transcends national level and geographical limitations (Henriksen, 2021). The policy creates an interconnection of different entities within a flexible environment that allows for some

autonomy (Laird et al., 2018). A transnational policy may have a common goal or objective but considers the needs of its audience and allows them to implement the policy based on these needs (Henriksen, 2021).

Assumptions, Limitations, and Delimitations

Researchers acknowledge numerous obstacles in assumptions, limitations, and delimitations in gathering and interpreting findings properly. According to O'Leary (2018), assumptions are not verified and believed to be factual, and limitations are areas of restriction. Delimitations are areas of exclusion from a study (Theofanidis & Fountouki, 2018).

Assumptions

Assumptions are presumed facts researchers consider true or conceivable, though there is no formal verification by the researchers (Collins & Stockton, 2018). One assumption in the current qualitative study was the approach would yield the desired results (see Queirós et al., 2017). Another assumption was participants would possess the prerequisite knowledge and experience managing a culturally and ethnically diverse workforce to help me achieve the research objective (see Queirós et al., 2017). I also assumed the participants would provide accurate and factual answers to the interview questions. Finally, I assumed the research findings would be helpful to similar organizations.

Limitations

Limitations are possible shortcomings that a researcher cannot control that may adversely influence the findings of a study (Collins & Stockton, 2018). In all qualitative

studies, a limitation is that the participants could provide false and misleading answers and responses (Queirós et al., 2017). A researcher should consider all options to verify the information provided by the participants (Gaus, 2017). A second limitation of the current study was the responses may have contained bias based on the participant's respective health organization and operations (see Queirós et al., 2017). A third limitation was that the study's findings might not be applicable to other organizations outside of the health sector and Iowa (see Colovic & Williams, 2020; Queirós et al., 2017). It is possible that leaders and managers in other industries are facing similar challenges based on the management of diversity; however, a limitation was that this qualitative multiple case study's results may not be applicable to other workplaces, populations, and industries. As with all case studies, limitations included credibility and dependability, and data collected were subjective.

Delimitations

Delimitations are the characteristics that limit the scope and boundaries of research (Gaus, 2017). The delimitations of the current study were sample size, industry, and geographical location. The selected participants were health care professionals with experience managing a culturally and ethnically diverse health care workforce. The geographical scope included the state of Iowa only.

Significance of the Study

Health care leaders and managers who fail to resolve diversity issues can impact their organization's performance. According to Di Fabio (2017), failures in diversity training risk an organization's financial standing, including expenses for an employee's

replacement. Cultural diversity could contribute to organization profitability resulting in positive social change.

Contribution to Business Practice

In a diverse workforce, communication among team members can become challenging (Duchek et al., 2019). Effectively managing diversity in the workplace is important because diversity affects the well-being of employees and customers, an organization's performance, and the organizations' financial performance (Di Fabio, 2017). Organizational leaders who fail to resolve diversity issues risk losing valuable workers while increasing recruitment expenses for replacements. When leaders embrace ethnic and cultural diversity, productivity can increase, problem-solving abilities can improve, and financial growth can occur (Dupont, 2016).

Implication for Social Change

An association exists between understanding the importance of managing diversity in health care organizations and making significant social change. An appreciation of diversity is essential for eliminating negative stereotypical beliefs about certain cultures, promoting fairness, and ensuring equality in an organization (Raewf & Mahmood, 2021). The implications for positive social change include the potential for hospital leaders to maintain harmony within an organization and the potential for hospitals to continue to have a positive economic effect on their communities and improve the quality of health care provided to patients.

A Review of the Professional and Academic Literature

The objective of this multiple case study was to explore the strategies leaders employ in health care organizations to manage an ethnically and culturally diverse population of employees and to increase the organization's profitability. Applying these strategies could promote cultural diversity, improve the levels of productivity and creativity, and increase profitability (Inegbedion et al., 2020). Despite the effectiveness of using a culturally sensitive management strategy, challenges exist in having a racially and ethnically diverse workplace (Cletus et al., 2018). Some leaders of health care organizations have insufficient skills and strategies for managing ethnically and culturally diverse employees and for obtaining the benefits of such strategies in the organization.

A significant amount of research has been conducted in health care areas; however, there is a paucity of case studies in the field of diversity in the workplace, specifically in Iowa. Part of the social implications of the current study was appreciating that organizational cultural diversity is critical to eliminating any negative cultural stereotypes, promoting fairness, and ensuring organizational equality (see Raewf & Mahmood, 2021). This appreciation is essential to ensuring inclusion and generating a sense of belongingness among employees, despite their cultural differences. Schunk and DiBenedetto (2020) suggested this sense of belongingness and harmonious working promotes job satisfaction and motivation that positively affect health care organizations' quality of care.

The current literature review contains 132 references, 105 (80%) of which were published within 5 years of the chief academic officer's anticipated approval of the study

in December 2021. In addition, the literature review contains 96 references (73%) from scholarly peer-reviewed articles. The remaining 27% consist of conference papers. The primary source of the professional and academic literature was the Walden University Library databases, including ScienceDirect, SAGE Premier, Emerald Management Journals, and EBSCOhost. I also used Google Scholar to search keywords to identify relevant articles and then researched through the Walden University Library to gain access to the literature.

I conducted a comprehensive literature review to address the problem of cultural diversity in the workplace. The databases searched were from credible medical databases from the Walden University Library databases. Gasparyan et al. (2016) highlighted that these databases contain credible, peer-reviewed studies suitable for introducing evidence-based practices. Because the current study addressed management, studies in business and management were also analyzed. I developed a search syntax from the study research question. The development of a search syntax simplifies the search process and is an effective strategy in conducting advanced searches (Duffy et al., 2016). The syntax also eliminates the numerous stages involved when conducting literature searches (Duffy et al., 2016). Finally, I used the Boolean operators OR and AND. These operators offer critical conjunctions when conducting literature searches (Jahan et al., 2016).

The keywords combined with the Boolean operators formed the search terms, which included *diversity*, *cultural diversity*, *workplace diversity*, *leadership in healthcare organizations*, *cultural diversity in healthcare organizations*, *managing cultural diversity in healthcare*, *cognitive diversity theory*, and *financial benefit of cultural diversity*.

Inclusion and exclusion criteria ensure only the most recent and relevant studies are included in a review (Patino & Ferreira, 2018). The current literature review begins with the conceptual framework, which was the foundation of the study.

Conceptual Framework

Cognitive diversity theory shows different perspectives from the cultural differences between members of an organization. The differences in perspectives of cognitive diversity stem from differences in gender, ethnicity, and age. The other aspects of cognitive diversity refer to ways in which individuals think about challenging situations. One challenge of cognitive diversity is health care leaders' and managers' ability to solve a wider range of problems effectively.

Cognitive Diversity Theory

A continuous debate exists regarding the relationship between diversity, innovation, and creativity. Proponents of cognitive diversity theory purport that diversity in the way that team members encode, organize and process information influences team learning through collective intelligence and affects the general ability of a team to work together across a wide array of tasks (Chua et al., 2015; Younis, 2018). Sanyang and Othman (2019) found that diversity is not necessarily tied to improved group or organizational performance. Other studies highlighted that increased diversity results in increased group and/or organizational performance due to improved innovation and creative problem-solving, including decision making (Ahmad & Rahman, 2019; Mulu & Zewdie, 2021). These variations are likely the differences because of the impact of

diversity on group or organizational members, which requires a need to understand individual differences.

Physical or biodemographic diversity, for instance race, age, or sex, positively affects individual performance. The rationale of physical diversity is that team members contribute their unique cognitive characteristics based on their experiences that originate from their demographic background (Kerga & Asefa, 2018; Stamarski & Hing, 2015). Task-related diversity has ties to improved group performance, as indicated in attributes that are not readily detectable, for example, education, expertise, and individual capabilities (Alexandra et al., 2021; Cizmas et al., 2020). Grim et al. (2019) highlighted that, in the early stages of work and task completion, homogenous groups tend to perform better than heterogeneous groups. In later stages, the heterogeneous groups begin performing better, particularly due to the availability of multiple ideas for solving problems.

According to cognitive diversity theory, performance improvements are due to the numerous perspectives and ideas from the culturally diverse members of a group (Chua et al., 2015; Younis, 2018). Diverse groups take more time to gel and efficiently work together because they are unfamiliar with each other, which may result in their dismal performance in the early stages of work or task completion. Also, groups with ethnic diversity have better cooperation than homogenous groups at tasks needing decision making (J. M. Jones & Dovidio, 2018). Ethnically diverse groups have also had a greater level of innovation and creativity (Duchek et al., 2019). Gavrilets (2015) and Tamunomiebi and Iyioriobhe (2019) determined that homogenous groups tend to have

greater efficiency; however, heterogeneous groups have greater effectiveness. Disparity in previous reasearch demonstrated that further study was needed to provide reliable findings that enable leaders and managers to successfully implement diversity strategies

Contrasting and Complementary Theory: Similarity-Attraction Theory/Paradigm

The focus of cognitive diversity theory is on the positive organizational impact of diversity, whereas the focus of the similarity-attraction paradigm is the negative effect of diversity on an organization (Şahin et al., 2019; Schaffer, 2019). Members belonging to diverse working groups have had lower levels of attachment to the groups and organizations and are often absent and likely to quit their jobs (Stamarski & Hing, 2015). Moreover, diversity in the workplace is a likely source of conflict and increased employee turnover (Gitonga et al., 2016).

The similarity-attraction theory is among the basic theories developed to explain the rationale behind the negative effects of diversity in organizations. The theory posits that persons are attracted to individuals who share similar attitudes (Schaffer, 2019). Beliefs and attitudes tend to be the antecedents to attract interaction, while attributes such as race, age, sex, and socioeconomic status reveal deeper personal traits. Studies on job seekers' behaviors have established that individuals have an increasing attraction to firms whose recruitment statements and images are reflective of their identity group (Baum et al., 2016). Companies perceived as valuing diversity in their recruitment process tend to attract persons from racial minority groups and women more than Whites (Baum et al., 2016). In addition, when firms use recruitment materials targeting minority groups, the

attraction for heterosexuals diminishes (Baum et al., 2016). Foreigners have a higher attraction to firms that recruit international employees with diverse backgrounds.

Diversity

Dealing effectively with diverse groups of people is important in the workforce, as demographics continue to shift. There is no universal definition of diversity, as the term has multiple definitions (Dobusch, 2017). Diversity often refers to the distinct variations existing between persons and groups; however, the ambiguity present within the distinctions comprises an exhaustive list of attributes (Dobusch, 2017). Diversity can refer to age, class, ethnicity, gender, physical and mental ability, race, sexual orientation, spiritual practice, and other individual human differences (Wambui et al., 2013).

According to the Office of Equity and Inclusion, Oregon Health Authority, diversity is the understanding and recognition that every person is unique and has individual differences (Patrick & Kumar, 2012). The differences are within the parameters of "race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies" (Patrick & Kumar, 2012, p. 1). Diversity refers to the human characteristics that vary from people's perspectives (Plotkin, 2011). I used the definition of diversity by the Office of Equity and Inclusion, Oregon Health Authority (Patrick & Kumar, 2012). The rationale was that it offered a broad understanding of diversity and considered all of the diverse human elements that may affect an organization; however, ambiguities remain regarding the distinct features of diversity (Dobusch, 2017). The definition by the Office of Equity and

Inclusion, Oregon Health Authority considers every unique human aspect as an element of diversity that can affect an organization based on how leaders manage the diversity.

Layers of Diversity

Diversity represents multiple individual differences and similarities among people. These attributes include race, age, national origin, religion, ethnicity, and sexual orientation. These attributes are provided in the four layers model of diversity posited by Gardenswartz and Rowe in 1994 (as cited in Maj, 2015). Within the model, diversity emerges as onion-like, with multiple layers that, if peeled off, reveal the core.

Organizational Dimensions. Organizational dimensions refer to the structure and general managerial mechanisms of the firm. Organizational dimensions are the outermost layer and comprise attributes, such as managerial status, affiliation to unions, location of work, divisional department, work content or field, and the functional classification level (Maj, 2015; Rathore, 2019; Shore et al., 2009). The attributes tied to this layer are items controlled by the firm where a person is employed. The employees have minimal influence on this layer because most of the control is with the organization where the individual works. This structural layer refers to the organization's backbone and internal dimensions needed to form a successful operation.

External Dimension. The external dimension refers to different perspectives or aspects that come from outside of the organization. These are attributes that deal with individual life choices (Maj, 2015). The individual has a higher degree of control over such characteristics than in the organizational dimensions (Shore et al., 2009). The attributes include personal and recreational habits, religion, educational background,

work experience, appearance, status, marital status, geographical location, and income. Furthermore, the external dimension could be from government policies and regulations, demand from customers, and environmental factors.

Internal Dimension. The internal dimension is the strong influence on behavior by the expectations and assumptions about others. The internal dimensions of diversity include attributes assigned to an individual, such as age, race, ethnicity, gender, and physical ability (Maj, 2015). These attributes are the origins of prejudice and discrimination. Individuals have the least influence and control over this dimension (Maj, 2015). Milliken and Martins (1996) considered this dimension as cultural diversity and described its features as the visible demographic attributes among team members. These discrepancies are likely due to differences in the impact of diversity on a personal level.

Personality. Personality is the combination of characteristics or qualities that characterizes an individual and forms the core of the other human dimensions (Maj, 2015). Personality determines specific consistencies in how individuals behave in a particular situation and over time (Maj, 2015). The other levels, such as openness, conscientiousness, extraversion, agreeableness, and neuroticism, affect an individual's personality. These layers shape an individual's perception, disposition, and actions as they interact with their surrounding environment (Maj, 2015). The individual perspective may consider a deep-level diversity described as differences in unique psychological attributes, such as beliefs, values, and attitudes (Schoss et al., 2020). People learn about diversity via extended interactions and the gathering of information, and difficult to detect.

Classification of Diversity

Information and Decision-Making Perspective. These are values, rules, and independent sets of variables and constraints to be considered when selecting an option in planning. Cox and Blake (1991) posited this perspective as a theoretical approach to understanding the correlation between organizational diversity and effectiveness. The rationale was that, until 1991, researchers asserted a connection between organizational diversity and efficacy, with some highlighting this interconnection using empirical findings (Scarborough et al., 2019); however, there were no studies at the time that proposed or tested the causal mechanism inherent in the connection, and it was left open to interpretation. The foundation of this perspective is the cognitive resource diversity theory, which posits that every team member's cognitive resources contribute to the team's overall success.

Social Organization Perspective. This is an interaction between two different groups without boundary. The basis of this perspective is the similarity-attraction paradigm posited by Horowitz in 2005, founded on the notion of social homophile. Homophile refers to an internal self-preference that is the tendency for an individual to have positive ties with people they deem similar to them in socially significant ways (Khanam et al., 2020). Homophile is a phenomenon that is well-established and often occurs within social and organizational networks where persons with the same contexts naturally connect (Khanam et al., 2020). Therefore, homophile is a social concept that an individual's network is significantly more homogenous than heterogeneous (Khanam et

al., 2020). In the organizational setting, individuals with similar tendencies work together more effectively.

The focus of social organization under this perspective is on common social categories as the means to access external networks and as a source of conflict between persons within social groups. The perspective recognizes that conflicts and inefficiencies in organizations relate to individuals' alignment and social identities (Khanam et al., 2020). Such an alignment can result in significant levels of conflict between social groups because the alignment replicates organizational tensions founded on the varying treatment of persons from different social groups (Khanam et al., 2020). Social identity results in temporal gaps and collective fences that create conditions in which functional diversity becomes less significant (Khanam et al., 2020). The influence is inconsistent, as Duchek et al. (2019) highlighted the positive and negative effects of social identity diversity with the implication being leaders become moderators in such relationships.

Workplace and Organizational Diversity

Workplace and organizational diversity refer to the multiple differences between organizational employees. Diversity includes race, gender, ethnic group, age, personality, cognitive style, tenure, organizational function, education, and background (Guillaume et al., 2017). Diversity involves self-perception, including the perception of others that affects their interactions. For employees with diverse backgrounds, including personalities, to function effectively in an organization, human resource professionals should effectively address issues tied to communication, adaptability, and change (Guillaume et al., 2017). Workforce diversity is also considered a process that develops

an inclusive environment where varying individual skills, cultural perspectives, and backgrounds are valued (Samuel & Odor, 2018).

Diversity Management

In the workplace, diversity management (DM) is a process of creating a working environment that values what every employee brings to the table as unique. Adopting DM is the commitment of an organization to recruit, select, reward, promote, and retain a diverse mix of employees at any point in time to recruit, select, reward, promote, and retain a diverse mix of employees (Samuel & Odor, 2018). The goal is to combine and use the blend of unique cultures. DM implies applying proactive efforts by all members within an organization to respond effectively to challenges inherent in working in diverse groups (Samuel & Odor, 2018). DM did not mean leaving the situation where you feel uncomfortable but learning from the situation.

DM is a process targeting the creation and maintenance of a positive work environment where individual value individual similarities and differences (Patrick & Kumar, 2012). This DM ensures all of employees reach their maximum potential and maximize their contribution to the goals and objectives of the organization (Patrick & Kumar, 2012). DM is further described as the planning and implementation of organizational systems and practices of people management for maximizing their potential advantages and minimizing the disadvantages (Olsen & Martins, 2012).

The focus of managing diversity is to build DM-related skills and transforming strategies and policies. The corporate strategy and mission drive the management of diversity, and all the employees and the firm experience the benefits (Kim, 2006). The

management of diversity offers a unique advantage to an organization when flexibility and creativity are critical to competitiveness. A firm should be flexible and adaptable to meeting new consumers and market demands (Kim, 2006). The rationale behind DM-related success is that heterogeneity promotes creativity and provides better solutions to problems and a greater level of crucial analysis, which is essential when an organization is undergoing significant change and self-examination to establish new and more effective ways of operating (Ayub et al., 2013). Effective DM develops a firm's reputation and hence attracts the best talent from a presently shrinking labor pool, which saves time and money in recruitment and turnover (Ayub et al., 2013).

Managing a diverse workforce has received significant attention compared to other concepts in the health care areas. Many heath care organizations consider DM as a source of competitive advantage (Urbancová et al., 2020). The concept appears simple when theoretically considered; however, it becomes increasingly complex when considering the implementation process. The other aspects of managing employees with diverse backgrounds create new perspectives knowledgeable and ideas by their cultural understandings.

Strategies of Managing Diversity

The change in demographics indicates that companies in the United States will not have a majority of their employees coming from one racial or ethnic group in the near future. The shift is toward an increasingly diverse population that will significantly affect the employees and organizational operations, including approaches to DM (Oyedele et al., 2018). In the future, health care firms who understand DM will have a competitive

advantage over others. A need exists to have specific strategies of DM, as discussed below.

Understanding. Understanding requires the comprehension of the nature and meaning of diversity to engage in DM both effectively and efficiently. The foundation of some managers' focuses on employment opportunities (Patrick & Kumar, 2012) is the legal perspective in which the law prohibits the discrimination of persons based on the internal attributes of an individual; hence, they should treat every person the same. This belief is problematic in the workplace, as everyone is unique (Christian et al., 2006). Although there should be fair and equal treatment, heath care leaders and managers should understand and consider individual differences when engaging in DM. Therefore, the strategy is to understand the individual factors that produce different behaviors and accept the differences.

Empathy. Empathy refers to the attempt to understand other people's perspectives in the workplace, for instance when a female joins a traditionally male-dominated organization or group. The men might be self-conscious or confused about how to act toward the new member, or even worried about ensuring her comfortability and ensuring she feels welcomed (Di Fabio, 2017). The males may also empathize with her feelings to boost her confidence and create a sense of belongingness. By learning and understanding other people's feelings, managers can facilitate their ability to help employees work together effectively.

Communication. Organizational problems become bigger when individuals are unwilling to engage in open discussions on issues tied to diversity. The strategy for

diversity in the workplace is establishing two-way communication (Ahmad & Rahman, 2019). The communication should be friendly and respectful with a willingness to avoid escalation. The strategy may involve third-party intervention by a manager or other suitable individuals within an organization.

Organizational Approaches. Individual managers and employees are critical in DM; however, health care facilities are also required to play a significant role. Through policies and practices, organizational employees can understand appropriate and inappropriate behavior (Maj, 2015; Patrick & Kumar, 2012). In addition, diversity training is a more direct strategy, with organizational culture being the most suitable context for managers to address diversity.

Organizational Policies. The starting point for DM is the policies adopted by health care facilities that have a direct or indirect effect on how people treat people. For example, the degree to which a firm embraces the concept of equal opportunity largely determines the potential of diversity existing in a firm (Abaker et al., 2018). Health care facilities that strictly adheres to the law and engages in passive discrimination is different from health care facilities that actively seeks diversity in the workplace. Another policy-related factor that affects diversity is how health care facilities respond to and deals with diversity issues. For example, placing an excess burden of proof on a victim of sexual violence and only minor sanctions on the manager charged with the crime highlights how seriously health care facilities consider sexual violence (Abaker et al., 2018). A firm that has balanced policies addressing such issues shows that diversity and personal rights and privileges are important.

The policies and procedures of the organization clearly use to guide and determine its present and future decisions. Among the policies that can demonstrate a company's position on diversity is the mission statement (Abaker et al., 2018). The mission statement should articulate a clear and direct commitment to individual differences (Patrick & Kumar, 2012). Every employee should understand and accept the need for diversity, and its importance, within the organization through the mission statement (Gurley et al., 2015). These broad concepts allow leaders and managers to put in place and practices within organization.

Organizational. Organizational is an individual's behaviors and actions to emphasis the change of the core values of an organization. An organization's procedures and practices, for example, by creating networks of different groups manage by leaders and managers. One attribute of diversity is multiculturalism; hence, health care facilities can successfully engage in DM by adhering to flexible policies and procedures (Abaker et al., 2018). For example, benefits packages, such as insurance, can accommodate personal situations. Single parent employees may need broader insurance coverage and may need to schedule their vacations to be in line with their children's school holidays. In addition, flexible working hours may consider family arrangements, religious holidays, and cultural events. For example, single parents and breastfeeding mothers may require different working hours and breaks. Therefore, engagement in DM requires leaders and managers to consider such diverse needs and attempt to accommodate them in their policies and practices (Cletus et al., 2018). Health care facilities may promote diversity by ensuring the management committees and executive teams are diverse. Even when

there is diversity in an organization, if such committees and groups are not diverse, the indication is that diversity is not fully engrained.

Diversity Training

Diversity training is a program design to facilitate positive intergroup communication, collaboration; decrease prejudice and discrimination from one to another. Diversity training is among the most effective means of DM and reducing health care facilities associated conflict (Cletus et al., 2018). Diversity training is customized training that allows an organization's employees to function within a diverse workplace (Cletus et al., 2018). For instance, health care facilities help employees learn about the differences and similarities within each other employees. The training involves teaching both genders to work with each other effectively and efficiently and provides insights into how others understand individual behaviors. An example is the perception held by employees that some behaviors evoked by male managers are sexist. In addition, teaching female employees will allow them to verbalize behaviors from the managers they considered uncomfortable without being hostile. The training may help persons from different races understand each other. In addition, health care facilities can offer language training to employees as a means of DM (Abaker et al., 2018). The reason for offering such training is skill enhancement and creating awareness of the importance of diversity.

Organizational Culture

A firm's organizational culture is the primary determinant or indicator of its leaders' commitment to DM. Regardless of what managers say or write, unless there is a foundational belief that diversity is valued at the organization, diversity will never be an

integral component of the organization (Simons & Rowland, 2011). An organization whose leaders intend to promote diversity must mold the organizational culture to underscore the commitment of the top management to support all forms of diversity in the organization (Samuel & Odor, 2018). Obtaining support from top management and reinforcing this support using clear and consistent policies and practices ensures diversity becomes a fundamental component of an organization.

Cognitive Diversity

Cognitive diversity is presence for individuals with different styles of problem-solving and unique perspectives thinking. Cognitive diversity refers to variations in beliefs, preferences, thinking styles and assumptions held by organizational employees (Liao & Long, 2016). Such diversity is manifested in a person's unique cognitive level and style. Cognitive level refers to a person's intellectual potential, such as intelligence, aptitude, and talent, and mental resources, such as knowledge, skills, and experience (Jablokow et al., 2015). Style refers to the process of organizing, processing, and conceptualizing information used by an individual for problem solving or decision-making (Jablokow et al., 2015). Therefore, cognitive diversity needs to be part of every employee's yearly training.

Cognitive diversity negatively affects cohesion, which may lead to tensions and conflict among organizational members. Mello and Delise (2015) employed a sample of 127 students from a midsize university in the United States. The students were in 38 teams comprising three to five members in each team. Cognitive diversity among the participants harmed group cohesion when there was minimal conflict management among

the team members but had no effect when conflict management was high (Mello & Delise, 2015). A similar situation also occurred among professionals in a study by Wang et al. (2016). The researchers collected data using pair surveys issued to 62 teams in 14 organizations and established that cognitive diversity affected the teams' intrinsic motivation, which directly affected creativity. Cognitive diversity is likely to negatively affect intrinsic motivation, which will have a consequent negative impact on team creativity (Wang et al., 2016). The rationale for the absence of cohesion is the social homophile principle, where people are inclined to find and interact more with persons similar to themselves and have minimal interactions with those they consider different from themselves. To cover up the gap inherent in social hemophilic interactions in a team, the use of mediating factors, for instance, leaders and managers take different communication perspectives. In addition, Wang et al. (2016) suggested using transformational leadership and cultural intelligence, as well as Mitchell and Boyle (2015) suggested applying open-mindedness to attain the full benefits of cognitive diversity within a team setting.

Researchers established that cognitively diverse teams have greater performance in team collaboration and performance. The rationale is that they can access numerous perspectives that are minimally available to teams that are not cognitively diverse (Liao & Long, 2016; Torchia et al., 2015). Researchers also integrate diversity via comprehensive processing. Sharing varying cognitive styles positively affects divergent thinking and performance in creativity; it also creates more errors in executing tasks than in teams with a homogenous cognitive style.

Benefits of Diversity Management in Organizations

Researchers have linked effective DM with multiple benefits including improve creativity and company reputation. Urbancová et al. (2020) identified and evaluated the practice of DM as a sustainability factor of competitive advantage in connection with diversity factors. Urbancová et al. (2020) used surveys to collect data from 549 Czech companies and established a statistical dependence between applying DM and the commercial sector where the firm operated and the organization's size. The health care facilities identified the primary benefits of DM as employee retention, improved performance and motivation of current employees, and improvement in the organizational atmosphere (Urbancová et al., 2020). Researchers should focus on the topic, as there is an increasing lack of qualified workforce (Urbancová et al., 2020).

Increasing workplace productivity is among the primary challenges for organizational managers and leaders. Every organization has a unique organizational structure and objectives, and leaders and managers can employ different strategies in challenging a company to increase productivity (Di Fabio, 2017). The strategies which studies show will work are ones that adopt diversity and engage in effective DM. When employees' welfare is effectively managed through proper compensation, health care, and appraisal, the employees develop a sense of belongingness to the firm regardless of the health care facilities background (Di Fabio, 2017). They become increasingly loyal and work hard, which increases productivity and consequently profitability. The effective DM allows the exchanging of ideas and enhances teamwork (Shaban, 2016). Teamwork in organizations is increasingly critical as it assures improved outcomes and effective and

efficient delivery of goods and services (Shaban, 2016). Every team member brings unique skills, knowledge, and ideas regarding task completion and problem-solving to provide the best solution in the least amount of time (Shaban, 2016). Oyedele et al. (2018) also established that diversity and effective DM result in superior decision-making outcomes. The rationale is that a diverse team approaches a problem with alternative views and perspectives that offer multiple possibilities that a homogenous group cannot generate.

DM also promotes learning and growth. Creating a diverse work environment allows personal growth, as employees are exposed to different cultures, ideas, and perspectives (Ekwochi, 2018), and enables individuals to develop clear insight regarding their position globally and enhance their immediate surroundings. When employees from diverse background spend time together, they can break through any existing barriers to become more experienced persons within the community (Ekwochi, 2018). Effective DM also ensures effective organizational communication (Okoro & Washington, 2012). The rationale is that such diversity strengthens an organization's relationship with a particular group of customers by increasing communication effectiveness (Chua et al., 2015). Among the critical areas affected is customer service, as DM will ensure employees are paired with customers from certain areas or locations who then feel at home (Chua et al., 2015). For instance, an American company working primarily with French-speaking customers prefers hiring bilingual individuals who speak French.

DM also allows employees to have diverse experiences, as the employees come from different backgrounds. Employees from different backgrounds have unique

perceptions and experiences in engaging in teamwork and group tasks (Ahmad & Rahman, 2019). Bringing together diverse skills and knowledge from individuals with different cultural backgrounds can have a significant positive effect on a company (Ahmad & Rahman, 2019), which may strengthen the organizational responsiveness and productivity and allow change adaptation. Each unique culture has its merits and demerits, and every employee in an organization has unique weaknesses and strengths that are culturally driven (Ahmad & Rahman, 2019). When leaders and managers accomplish each of these attributes adequately, the organization can benefit from the employee strengths and complement the weaknesses, which results in a high-impact workforce (Ahmad & Rahman, 2019). Inegbedion et al. (2020) examined the effect of DM on organizational efficiency. Inegbedion et al. (2020) targeted finding the degree to which DM influences the efficiency of an organization by managing cultural conflict and diversity and the perception of marginalization among employees, including teamwork and the attitude employees have toward work. Inegbedion et al. (2020) collected data from 178 respondents using surveys. The respondents were generated from nine multinationals in South Nigeria. The results revealed that managing culturally diverse employees, as well as their perception of marginalization and conflict, influenced DM. DM and teamwork significantly influenced the organization's efficiency (Inegbedion et al., 2020). The review of the literature revealed a need for research on managers in diverse organizations who consider DM and ensure its effective implementation.

Overview of Health Care

Importance of the Health Care System and Organizations

Health systems have a critical and continuous responsibility for the population's health throughout its lifespan. These systems are vibrant for individual, familial, and societal development (Crowley et al., 2020; Kruk et al., 2018). Real progress and attainment of the Millenium Development Goals, including other national priorities, are dependent on stronger health systems founded on primary health care.

Health improvement is the primary objective of every health care system; however, it is not the only objective. Good health as an objective is two-pronged: the best achievable average (goodness) and the least feasible differences among different individuals and groups (Azétsop & Ochieng, 2015; Öhman et al., 2015). Goodness means the system and organization properly respond to people's expectations, while fairness means that the system and organization respond equally to everyone without prejudice or discrimination (Azétsop & Ochieng, 2015; Öhman et al., 2015). Every national health system based on the World Health Organization standards should work to attain three goals: good health, responsiveness to the population's expectations, and financial contribution fairness (Khan et al., 2021). Progress toward attaining these goals is dependent on how effectively the system or organization engages in four key functions: service provision, resource generation, financing, and stewardship (Khan et al., 2021; Manyazewal, 2017). Health care systems or organizations ensure equal access to quality services for acute and chronic care needs health-promoting and disease-preventing services, and appropriate response to emerging threats.

Overview of the U.S. Health System

The U.S. health care system employs the private insurance model, also known as the independent customer model (Crowley et al., 2020). The basis of funding within this system is premiums and payments made to private insurance companies, which reflects a system that only exists in the United States (Crowley et al., 2020). In the U.S. system, most of the funding is generated privately, except for social care for poor and elderly persons via the Medicare and Medicaid programs funded by the government (Crowley et al., 2020). The country's health care system is not nationally uniform. As highlighted by Obama (2016), the U.S. health care system has a mix of payment structures with varying types of insurance that exist parallel to each other, which leads to an inefficient and highly fragmented system with no universal health care coverage.

As is the case in most nations, the health care system in the United States has both private and public insurance providers. The primary sources of payment are the Centers for Medicare and Medicaid Services (public) and state-specific nonprofit Blue Cross Blue Shield and private commercial insurers (Doonan & Katz, 2015; Obama, 2016). The public and private insurance programs vary in relation to the benefits covered, financial sources, and health care providers' payments.

Americans who lack insurance coverage use safety-net health systems (Chokshi et al., 2016). The U.S. health care system provide essential health services via inpatient, emergency, and ambulatory care. The core safety-net providers ensure access to health care services regardless of a person's payment capability, with its primary patient population comprising mainly uninsured or Medicaid patients, including those who are

ineligible for public health care insurance programs (Chokshi et al., 2016; Warner et al., 2020). This population relies on subsidies and charitable donations to pay for their health care costs, which leads to low operating margins within safety-net facilities.

The Patient Protection and Affordable Care Act (ACA) introduced an additional insurance option for Americans. The ACA was a novel model for health care delivery that included accountable care organizations (ACOs; Zhao et al., 2020). ACOs are clinical enterprises that influence the financial risk of providers by providing incentives to insurance provision improvements (Bartels et al., 2015). The ACO is a system of delivering health care with either Medicare or the private payer model and includes a network of providers responsible for the quality and cost of care for a defined group or population of patients (Wilson et al., 2020). ACOs were inspired by integrating health care delivery systems within the private sector, for example Kaiser Permanente and Geisinger Health System (Slotkin et al., 2017). Therefore, the ACA's goal is to provide financial incentives to ensure a coordinated and deliberate adequate use of high-quality care.

The insurance marketplaces for ACA is accessible through websites and toll-free numbers, which allows the provision of insurance coverage that is independent of any preexisting conditions (Doonan & Katz, 2015). The ACA offers health care users different choices of coverage, which increases competition between insurance providers and consequently reduces costs, improves quality, and increases the number of persons covered (Campbell & Shore-Sheppard, 2020). Under the ACA, insurance providers can bring together the small individual insurance market with the small group insurance

market and hence reduce payer risk and increase the variety of insurance coverage options for consumers (Doonan & Katz, 2015).

Diversity in U.S. Health Care Organizations

Medicine, specifically health care delivery, is a diverse field serving a diverse population. Health care diversity supersedes the language barrier and requires the comprehension of a patient's mindset in the broader context of cultural, gender, sexual orientation, religious beliefs, and socioeconomic realities (Grandpierre et al., 2018). When a homogenous health care team must care for a diverse group of patients, the quality of care provided may be negatively affected (Grandpierre et al., 2018). Different segments of the population are affected differently by existing health disparities (Dassah et al., 2018). Health care and treatment attitudes vary among populations, and leaders and mangers expect care providers to offer customized care that acknowledges and recognizes individual differences (M. Johnson et al., 2017). Therefore, diversification is needed in the health care system and within health care organizations to meet the diverse needs of the service users, among other multiple benefits discussed later in this literature review.

Homogenous Origins of Health Care

Historically, the medical profession in the United States comprised mainly White male doctors and White female nurses (Fiscella & Sanders, 2016). During World War I, women took up posts in hospitals that would ordinarily have been occupied by men (Fiscella & Sanders, 2016). The professions continued to be primarily male-dominated (medicine) and female-dominated (nursing; Fiscella & Sanders, 2016). Health care

diversity in the early periods of the profession was a foreign concept, as individuals did not foresee a situation where patients would receive care from persons from a different background than their own (Mukharji et al., 2020). For example, White patients in the past did not accept treatment from Black practitioners (Lee et al., 2018). The homogenous nature of the health care professions was gradually eliminated (Lee et al., 2018). This diversity strategy began at the training level as medical schools began taking in a more diverse population of applicants, including an increasing number of individuals from racial and ethnic minority groups (Lee et al., 2018; Mukharji et al., 2020). Although the field of cultural diversity has significantly improved, resulting in a more diverse profession, it has yet to achieve full diversity and, of significant concern, from reflecting the diverse population it serves.

Current Demographics

The United States health care field was comprised of a majority of Christian White males from high socioeconomic backgrounds (Imadojemu & James, 2016). Ethnic and racial minority groups are significantly underrepresented in the field. Of those that are in the health care field, three fourths are physicians and surgeons. (Imadojemu & James, 2016; Velasco-Mondragon et al., 2016). Approximately 20% of the physicians and surgeons with <5% being Black and the Hispanic and native populations being the lowest represented the population in the health care fields (Imadojemu & James, 2016; Velasco-Mondragon et al., 2016). In addition, about two thirds of the practicing physicians and surgeons are male, which is likely to become more balanced over time (Imadojemu & James, 2016; Velasco-Mondragon et al., 2016). The difference between

graduating male and female practitioners has significantly changed over the past few decades (Kaplan et al., 2017; Stewart, 2021). Most medical students are from high socioeconomic backgrounds (Kaplan et al., 2017; Stewart, 2021). Therefore, students from low socioeconomic backgrounds are significantly underrepresented and are more likely to drop out from medical school within 2 years of their enrollment (Kaplan et al., 2017; Stewart, 2021).

In connection with faith, the medical field is primarily a Christian profession (Sallam & Sallam, 2017). Approximately two thirds of American physicians and surgeons are Christians, 14% are Jewish, 7% are unaffiliated, 5% are Hindu, and 3% are Muslim (Sallam & Sallam, 2017). The different ethnic groups above are compared to a population of 70.6% Christians, 1.9% Jews, 0.9% Muslims, 0.7% Hindu, and 22.8% unaffiliated with any religion (Silver et al., 2021).

Extensive research on sexual and gender diversity in the health care area is currently lacking. However, the results from one study showed that approximately one third of sexual minority groups at Stanford University opted not to reveal such information while in medical school (Albuquerque et al., 2016; Sallam & Sallam, 2017). Forty percent of participants in Albuquerque et al.'s (2016) study indicated that they experienced discrimination, which explained their fear of disclosure. Some medical schools have made efforts to ensure they enroll lesbian, gay, bisexual, transgender, and queer (LGBTQ) applicants (Albuquerque et al., 2016). As a result, the schools have reported an increase in the number of students identifying as LGBTQ.

A report by researchers for the U.S. Department of Health and Human Services (HHS) showed Hispanics are largely underrepresented in every occupation related to health diagnosing and treatment (Hall et al., 2016). Among the non-Hispanic population, African Americans are the most underrepresented population in all health care occupations except among dieticians and nutritionists (15%) and respiratory therapists (12.8%; Hall et al., 2016). Asians are underrepresented within the fields of speech-language pathology (2.2%) and advanced practice registered nurses (4.1%; Hall et al., 2016). American Indians, including Alaska Natives, are underrepresented in all health care professions except for physician assistants (Salsberg et al., 2021). This group is also the lowest among dentists and physicians, at less than 1% for each of the occupations. Recent population estimates show the country's racial and ethnic demographics as 76.3% White, 13.4% African American, 1.3% American Indian and Alaska Native, 5.9% Asian, and 0.2% Native Hawaiian and another Pacific Islander (U.S. Census Bureau, 2020). In addition, 2.8% reported as multiple races, and 18.5% reported as Latino/Hispanic (U.S. Census Bureau, 2020).

Need for Diversity in Health Care Organizations

About half of the U.S. population will be persons of non-European origin by 2050. Moreover, over 10 million of the U.S. population presently identifies as LGBTQ. The middle class shrank to 45% in 2018 from 57% in 1970 (Lichter et al., 2017). By 2043, there will be no single group comprising the majority (Lichter et al., 2017). In addition, population projections indicate that, by 2060, approximately one of every three Americans will be Hispanic (Alba, 2018), up from one of every six people in the country

in 2018. Similar changes will occur in the African American population, which could increase by 14.7% to 61.8 million by 2060. Further, by the same year, the population of Asian Americans could reach 34.4 million, which is double the 2018 population, and will comprise 8.2% of the country's total population (Alba, 2018). The number of international immigrants is projected to increase by 41.2 million by 2060.

Other projected changes in the U.S. demographics include an increase in the number of aging Americans. Based on current trends, it is projected that, by 2060, the elderly population (persons aged 65 years and above) in the United States will double to 92 million (Alba, 2018). Persons aged over 85 years will increase to 18.2 million and make up 4.3% of the country's total population (Alba, 2018). Finally, 2018 estimates of the American population by the U.S. Census Bureau showed that less than half of the country's children aged 15 years and below was a single race: non-Hispanic White (Alba, 2018). The changes in the population diversity as highlighted above are projected to continue with the projections indicating that persons with multiple races are expected to have the greatest population increase in the country through 2060.

These demographic changes are driving an increase in diversity in the country. In the context of these changes, the health care system and health organizations must work to provide culturally relevant, effective, and efficient treatment. Health care organizations and their practitioners must deliver health care that factors in the ethnicity, religion, gender, age, sexual orientation, socioeconomic status, language, education, ability, and geographic background of the users of its services. Service users tend to have overlapping identities, as each patient has a unique view of the world often influenced by cultural

background. There is no universally accepted definition of culture; however, the definition applied in this study will be that by Madeleine Leininger (Brottman et al., 2020; McFarland & Wehbe-Alamah, 2019).

Culture is the learned, shared, and transmitted values, beliefs, norms, and lifeways of a specific group of employed individuals used to guide their thinking, decisions, and actions in patterned ways that are often intergenerational (Brottman et al., 2020; McFarland & Wehbe-Alamah, 2019). Patients perceive health promotion and treatment based on culture, and this perception affects their health. Culture has the potential to affect everything ranging from the perception and understanding of medicine to individuals' acceptance of treatment by a physician of a different gender (Brottman et al., 2020; McFarland & Wehbe-Alamah, 2019). Thus, a person's background has an inextricable and meaningful relationship with health needs, care, and outcomes.

The U.S. annual increases in diversity shows the natural progression would mean the country's fundamental institutions, for instance, the government, schools, and health care facilities, should incorporate diversity within employees and functions to meet the needs of the population. Although all of these institutions are critical, government, schools, and health care organizations can have a direct and negative effect on the entire population when their members are not diverse and lack cultural competency. In health care field specifically, diverse potential decreases how employees interact with customer satisfaction.

The medical field is making significant strides in incorporating a diverse spectrum of doctors and other care professionals, but more still needs to complete. The lack of

diversity in health care organizations may have deleterious consequences on the patients who seek care from practitioners who understand their special needs (Perry et al., 2018; Shepherd et al., 2019). Examples here include transgender, gay, or patients from cultural minority groups. Cultural and sexual minority groups experience challenges accessing health care from competent care providers (Nair & Adetayo, 2019; Shepherd et al., 2019). The better the diversity of health care providers, the more effectively they can provide competent care that can effectively assist their patients. A homogenous workforce limits the capabilities and potential of health care provision and medical practice as it contains the practice within the limits of one perspective of care and one set of values (Nair & Adetayo, 2019). The existing organizational workforce should reflect the diversity of the patients they serve.

Diversity is critical in every profession. In the health care context, care practitioners and other employees working in health care organizations coming from a variety of cultures and backgrounds enrich the institutions by sharing their different perspectives with their workmates and colleagues (Shepherd et al., 2019). These perspectives improve the care provision processes and help health care facilities understand and respond to patients' needs. Diversity among care providers is critical, as they serve a diverse population of service users. Diversity leads to a better understanding of service users' values and belief system that leads to the provision of better health care (Jongen et al., 2018). When service users are unable to find care providers who have the competency to provide care that is in accordance with their beliefs, culture, or other facets of their culture, they may delay or not seek care (Nyblade et al., 2019). The lack of

diversity makes it increasingly intimidating to seek medical care for a particular group of patients, which may result in deleterious outcomes.

Different service users have different cultural beliefs and perceptions related to diseases and treatments. If culturally competent care is lacking, a barrier arises that limits the health care access and health-seeking behaviors of service users from such groups (Nyblade et al., 2019). Better diversity in health care organizations is an effective way to address the barriers that service users experience while seeking care and contributes to improvements in the quality of care provided (Cletus et al., 2018).

Health care diversity begins in medical school. Increasingly diverse classes benefit an entire group of students through the wider perspectives each student brings to the classroom (Serdyukov, 2017). Diversity in such a learning environment improves the learning outcomes for every student. Classroom diversity promotes active thinking, intellectual engagement, social skills, empathy, and racial understanding (Darling-Hammond et al., 2020). These are important factors inherent in the education of any health care practitioner. For example, physicians must have knowledge and be able to apply competency in medicine but also be able to communicate and provide care for persons with varying disease burdens and who face with varying social and cultural realities, values, beliefs, and expectations (Flynn et al., 2020).

Health care providers in the globalized world need to understand the wide array of service users they must serve. Global competence for a diverse population is what health care providers should provide and teach students in medical schools (Flynn et al., 2020).

These students will transfer this knowledge to health care organizations that ensure they provide care to diverse populations of service users.

Health care diversity is not simply about filling organizational positions with the required number of employees. Diversity in health care organizations involves ensuring there is an adequate representation of all backgrounds, beliefs, ethnicities, and perspectives within the medical field and health practice (Kaihlanen et al., 2019). The goal is to ensure all of service users receive the highest quality of care. Therefore, health care facilities should ensure they remain committed to greater representation in health care (Albougami et al., 2016). This diversity will improve patient outcomes, build stronger communities, and increase employee and patient satisfaction.

Increasing accessibility to health care education and encouraging a broad range of applicants is critical to reducing any higher education barriers. Greater accessibility to health education leads to a diverse population of health care practitioners being trained, which will ensure cultural competency and will meet the health care needs of the diverse population (Nair & Adetayo, 2019). Diversity accessibility will also lead to the effective and efficient work and collaboration of a diverse team of health care providers. Further, institutions of higher learning should also promote inclusivity by creating inclusive learning environments, spreading awareness through education and sensitization, and empowering students (Handtke et al., 2019). Providing support services such as mentorship programs both at higher learning institutions and health care organizations can promote positive learning and interactions, respectively, among diverse populations

(Feyissa et al., 2019; Manzi et al., 2017). This chapter includes further in-depth discussion of these positive effects.

Risks of Lack of Diversity

Research in 2016 highlights the consequences tied to a lack of diversity in health care organizations (Brooks et al., 2019). The risks emanate from the breakdown of the health management principles, including the elements of management. These risks highlight the need for an importance of diversity and DM in health organizations (Goode & Landefeld, 2018). One risk is communication breakdown. The lack of diversity and proper DM often leads to language barriers, different philosophical understandings and approaches to care, varying cultural norms and expectations, or cultural biases within an organization (Croucher et al., 2015). A communication breakdown between employees can misinformation to the patients (Brooks et al., 2019). When employees cannot understand each other and cannot adequately communicate with the patients, each of these groups will not be able to fully express its needs (Brooks et al., 2019), which increases the likelihood of mistakes occurring and the risk of adverse events in the organization. Further, miscommunication may promote high staff turnover, which will reduce the organization's productivity and lead to losses.

A lack of diversity indicates that a health care organization will have limited perspectives. Considering the current and projected demographic changes in the U.S. population, diversity in health care organizations could help increase the understanding of the different parameters inherent in diverse populations among employees and patients (Kabisch et al., 2015). A lack of diversity means that employees will have limited

perspectives when interacting with each other and when providing medical care, psychological treatment, and social support (Gopalkrishnan, 2018). Such an environment hampers creativity and innovation and impedes vital observations when making diagnoses, taking patients' history, or factoring in other socioeconomic factors affecting the health and well-being of patients (Vardaman et al., 2020).

A lack of diversity also indicates that organizational employees will lack role models to emulate. Important to the health care system and the continuity of health care organizations is mentorship (Metwally et al., 2019). Health care personnel need the support of experienced mentors who offer guidance in their respective areas of practice. Organizational employees in the health care system should have role models to emulate in their practice (Ozturk & Tatli, 2016). Lack of diversity and proper DM make it difficult, particularly for minority care providers, to find mentors to identify with and learn from, which hampers their professional growth and their potential to offer the best care to their patients (Metwally et al., 2019; Ozturk & Tatli, 2016). The quality of patient care diminishes over time, including the growth and sustainability of the health care organization.

The less diverse the medical staff is, the more difficult it will be for the organization to promote diversity in the future (Brooks et al., 2019). This promote diversity is partly because of a lack of mentorship and experience with DM (Hagqvist et al., 2020; Zambrano, 2016). Finally, a lack of diversity often creates bias (Guillaume et al., 2017). Even the nonexplicit form of bias can affect decision making when bias is

inculcated in the organizational policies and procedures (Zestcott et al., 2016). Important diversity in a health care organization can prevent the negative effects of bias.

Health Care Organization Management

Health care management and administration refers to the administrating, managing, or oversight of health care systems, public health systems, hospitals, hospital networks, or other medical facilities (Maina et al., 2019). Health care managers in this context have the duty to ensure the efficient running of the organization and its departments, the efficient recruitment of qualified employees, the efficient dissemination of information, the attainment of certain outcomes, and the proper use of resources (Karamitri et al., 2017). General managers oversee the entire organization, while specialist managers have a managerial focus on specific departments, for example marketing, finance, human resources, policy analysis, and accounting.

Health Management Principles. Health management principles are the core underlying factors forming the basis of successful management. These principles act as the statements of fundamental truths and provide managers with decision-making and action-taking guidelines (Godwin et al., 2017). The principles develop from observing and analyzing events that organizational managers confront within their daily practice (Uzohue et al., 2016). The principles include unity of command, equity theory, esprit de corps/team spirit, work division, authority and responsibility, discipline, individual interests' subordination, directional unity, remuneration, degree of centralization, scalar chain, order, stability of staff tenure, and initiative.

Unity of Command. Unity of command is one authority to direct all forces. The unity of command principle posits that each junior employee should receive orders and be accountable to a single superior (Bacud, 2020). If orders come from multiple superiors, there is a likelihood of conflict and confusion arising. Unity of command makes it easy to identify mistakes and the person responsible, including handling the mistakes (Al Mosawi, 2019). Therefore, having unity of command ensures minimal conflict in the instructions provided, with the only challenge being that loyalty may be given to one superior.

Equity Theory. Equity theory is a comparison of inputs and outputs to others in similar work situations. The theory of equity posits that all employees should be treated kindly and justly in the workplace (Bacud, 2020). The management should exercise fairness and impartiality when dealing with employees (AlJaberi et al., 2020). Therefore, health care leaders and managers should consider the employees' diverse needs and capabilities within the organization.

Esprit de Corps/Team Spirit. In team spirit, managers must engage in the development and sustainability of workplace morale at the individual and community level (Nobus, 2016). Team spirit is significant to develop a trusting and understanding environment. (Nobus, 2016). Team spirit ensures effective and efficient task completion and may address any work challenges that may emerge, including those tied to diversity.

Work Division. Work division involves work specialization based on one's skills and capabilities. It also involves creating specific professional development among the

organizational employees (Bacud, 2020). Such professional development increases productivity and results in greater specialization leading to greater workforce efficiency.

Authority and Responsibility. Administrative health care leaders and managers are authority and responsibility mean the right of a superior to issue orders to subordinates and the obligation of the subordinates to follow the orders. According to the principle, parity should exist between authority and responsibility (Chandler et al., 2016). These two factors coexist and work in unison.

Discipline. Discipline includes conducting oneself properly toward others and respecting authority. Discipline is key for the smooth running and functioning of health care organizations (Bacud, 2020). It ensures proper staff interaction, conducting activities effectively, and meeting organizational objectives with minimal resistance.

Individual Interests' Subordination. This principle demands that management should set aside personal considerations and interests and place organizational objectives first. Therefore, meeting the organizational goals should supersede personal interests (Moyo et al., 2016). The insubordination, leaders and managers of organizational goals for personal interests may create conflicts that may have a negative impact on the care provided and the entire organization.

Directional Unity. Every individual working in the same line of duty should understand and pursue similar objectives (Aggarwal et al., 2019). All related tasks and activities should be in a group, with one action plan established to complete them, and be ideally placed under a single manager (de Zulueta, 2016). The goal of the principle is to ensure unity in action, focus efforts, and strengthen coordination.

Remuneration. Remuneration is a requirement under this principle such that employees should receive adequate pay as their primary motivation (Karalis & Barbery, 2016). Remuneration has a significant influence on individual and organizational productivity and profitability. This is among the central areas affected by diversity, as evident in wage differences among different groups of health care workers from diverse cultural backgrounds (Karalis & Barbery, 2016). The amount and methods of payable remuneration should be fair, reasonable, and commensurate with the effort of the employee.

Degree of Centralization. The amount of power the central management holds depends on the size of the organization (Nay et al., 2016). Centralization herein means concentrating the decision-making authority at the top management level (Bacud, 2020). Health care facilities must strive to achieve an adequate power balance at the top and bottom to ensure operational efficiency and effectiveness.

Scalar Chain. According to the principle of scalar chain, a clear line of authority should be established in health care organizations (top-bottom) and link the managers at all levels (Hunter, 2016). The chain is the chain of command and involves the gangplank concept, where subordinates are able to contact their superior or their superior's superior during an emergency, hence defying the hierarchy of control.

Order. Order ensures health care organizations operate flawlessly through established authoritative procedures. For example, material order ensures workplace safety and efficiency (Bacud, 2020). Order also ensures all activities in an organization are allocated appropriately and performed seamlessly between different departments.

Stability of Staff Tenure. Stability of staff tenure refers to the period of service for employees in an organization or department (Bacud, 2020). Ideally, there should be a balance: employees should not serve in a particular department for either too long or for too short a period. Employees are unable to provide useful and effective services if they are removed from specific departments or work areas if they are not yet accustomed to the work assigned (Vardaman et al., 2020). In addition, they would be unable to engage effectively with the diverse staff within those departments, which affects their relationship and consequently care provision.

Initiative. According to the initiative principle, using employees' initiative can strengthen and provide novel ideas to an organization (Bacud, 2020). Employee initiative is a source of organizational strength, as it provides new and improved ideas. When employee initiative is allowed in a health care organization, employees gain greater interest in the organization's functioning (Bacud, 2020). Where a diverse population exists, health care leaders and managers can generate even more innovative and creative ideas.

Transition

Section 1 included the background information related to DM, including a description of the study's rationale and the rationale for selecting the research question. Section 1 comprised the problem and purpose statements, the nature of the research, and the research and interview questions of the study, including the significance of the study. Also, Section 1 provided an exhaustive literature review on diversity, including the aspects of diversity, the classification of diversity, organizational and workplace

diversity, diversity management, strategies of managing diversity, cognitive diversity, and the benefits of DM in organizations.

Section 2 includes an explanation of the case study, its purpose, the researcher's role, the research methodology, the study design, and sample and sampling techniques. Section 2 also includes data collection and validation techniques, ethical considerations, the data analysis process, and considerations for reliability and validity. Section 3 contains the study's findings, recommendations, implications for social change, my reflections, and conclusions.

Section 2: The Project

Purpose Statement

The purpose of this multiple case study was to investigate strategies that leaders of health care organizations use to manage workers from diverse ethnic and cultural backgrounds to increase performance. Eight health care professionals, managers, and administrators in the state of Iowa with success managing a culturally and ethnically diverse workforce served as participants in this study. Applying or adapting strategies that other leaders have used to manage cultural diversity in health care organizations may have positive implications. Cultural diversity can improve productivity levels, increase creativity, and provide beneficial social change to the communities involved (Inegbedion et al., 2020). The health care facilities in the current study were those providing and receiving health care from a culturally diverse organization.

Role of the Researcher

I was the primary instrument for data collection in this qualitative study. The researcher's job is to interpret the participants' actions, behaviors, opinions, and knowledge (Clark & Vealé, 2018). I was accountable for maintaining the rigor and integrity of various research areas as a qualitative researcher. Using a multiple case design enables researchers to compare results regarding a phenomenon from multiple organizations (Collins & Stockton, 2018). I had no personal connection to any of the eight health care professionals, managers, and administrators in the state of Iowa with success managing a culturally and ethnically diverse workforce.

After receiving permission from the Walden University Institutional Review Board (IRB), I followed the ethical principles laid out in the *Belmont Report* (U.S. Department of Health and Human Services, 1979), and by so doing I treated participants with respect and equality, safeguarded their privacy, obtained their informed consent, and educated them on the benefits and drawbacks of participating in the study. A qualitative researcher is responsible for preserving honesty and integrity and for safeguarding participants' rights (Friesen et al., 2017). I made certain to explain the study to potential participants without prejudicing them, conducted the interviews consistently, took the necessary field observations, and analyzed and interpreted the data in accordance with the research methodology. Respect for participants, doing good for participants, and treating participants equally and impartially are all criteria that researchers should follow to maintain integrity.

Researchers should detect their biases and establish measures to limit prejudice during the study process (Cypress, 2017). Bias refers to anything that can influence or distort the outcomes of a study (Galdas, 2017). A researcher's views, experiences, and knowledge about the topic can influence their perception during data collection. Information from the literature review, aspirations for the study, and human impulsivity can emerge during the research period, distorting what participants hear. I did not have prior experience in this field. My interest in health care comes from its significance as an essential service. I have a keen interest in the strategies that leaders of health care organizations use to manage culturally diverse workers and increase performance.

Unlike quantitative researchers, qualitative researchers lack many safeguards that statistical methodologies, standardized measures, and traditional designs provide (Rosenthal, 2016). Participants' and researchers' biases, beliefs, and attitudes can affect data reliability and validity (Spiers et al., 2018). Qualitative researchers must rely on their abilities, honesty, and transparency (Queirós et al., 2017). As a result, their function as a researcher falls under intense scrutiny.

The researcher's job entails being aware of and decreasing their predisposition to interpret information too soon (Castillo-Montoya, 2016). Thus, qualitative researchers have developed a range of methodologies. A multiple case study design helped me avoid having a personal bias during data collection. By allowing participants to freely communicate their perspectives, experiences, and opinions without interruption or intrusion of my thoughts or ideas, I limited bias and avoided viewing data through a personal lens. I made sure to maintain a clear perspective during the case studies and data analysis. I conducted interviews and used a protocol (see Appendix A) to help mitigate any researcher bias. Researcher bias refers to ensuring the interview protocol includes everyday language or terms, one question a time, and no jargon (Castillo-Montoya, 2016). I avoided viewing data through a personal lens by allowing participants to express their perspectives, experiences, and opinions freely without the interjection of my thoughts or beliefs. I adhered to the interview protocol, performed member checking, and maintained a reflexive journal to record my thoughts during participant interactions.

Participants

In qualitative investigations, researchers need to set specific criteria to identify individuals who are relevant to the research goal (Queirós et al., 2017). The selection of participants in the current study followed the eligibility requirements. The key for the research was to focus on participants with relevant knowledge and experience of the studied phenomenon, which was health care management (see Aggarwal et al., 2019). The participants for this study were health care professionals, managers, and administrators in the state of Iowa who had success managing a culturally and ethnically diverse workforce. The participant eligibility criteria included (a) living and working in the state of Iowa, (b) having a minimum of 5 years of experience in a health management position, (c) holding a professional medical license or health care management professional certification, and (d) currently leading or having led a culturally and ethnically diverse workforce in health care.

The health care leaders and managers included doctors, nurses, and medical managers. I contacted a senior leader in the medical area who served as a gatekeeper for gaining access to participants. Gatekeepers can provide access and help introduce researchers to valuable participants (Peticca-Harris et al., 2016). I presented a detailed description of the study's goal, the intended use of the collected data, and ways the findings may be valuable to the firm's operations and performance. To acquire authorization and access to a list of participants who fit the eligibility criteria, I requested that the respective health care leaders and managers read and sign a letter of cooperation and confidentiality (see Appendix B) and informed consent form.

Researchers can connect and acquire in-depth access to participants' experiences by creating rapport and trust. Implementing measures to create a workable and stable dynamic with participants may result in high-quality data and make the study's goals easier to achieve (Yeong et al., 2018). Researchers can employ practical tactics such as explaining the research objectives clearly and explicitly, establishing confidentiality protocols, organizing interviews at convenient times, and conducting interviews at a predetermined place (Guest et al., 2016). The medical association's senior leader provided me with a list of names and email addresses of potential participants who matched the qualifying criteria. I asked the senior leader to read and sign a letter of cooperation and confidentiality (see Appendix B). I sent a participant invitation to the potential participants through emails after I received the list of those eligible, seeking their involvement in the study. I enrolled participants who understood what the study expected. Doing this enhanced credibility of the findings.

The decision to adhere an interview protocol (see Appendix A) was to obtain the best information from the participants in my study. The interview protocol ensured the interview questions aligned with the research question and helped me construct an inquiry-based conversation. In writing the protocol, I used my knowledge of contexts, norms, and everyday practices of potential participants.

Research Method and Design

The successful completion of a research study requires selecting an appropriate research method and design (R. B. Johnson & Christensen, 2020). The three types of research methods available to scholarly researchers are quantitative, qualitative, and

mixed-methods. The method selected for the current study was qualitative. The chosen design for this study was a multiple case study.

Research Method

Quantitative researchers strive to explore variables' properties or interactions using numerical data to generalize from a sample (Creswell & Poth, 2016). The quantitative method was not applicable for this study. Quantitative and mixed-methods research were not suitable for this study because they both require data analysis and hypotheses testing to explore associations between variables, which was incompatible with the purpose of this study and the research question. Researchers who use mixed-methods collect, analyze, and use quantitative and qualitative techniques (Venkatesh et al., 2016). Qualitative researchers delve into participants' underlying meanings and motivations to understand a phenomenon (Park & Park, 2016). Researchers employ qualitative research methods to learn more about how and why a phenomenon occurs (Fusch et al., 2018).

Qualitative research entails examining the knowledge and understanding of a phenomenon through the experiences of a group of people or a program and developing systematic interpretations to generate new hypotheses (Mohajan, 2018). The qualitative technique matched well with exploring the in-depth knowledge of the subjects. Researchers who study participants' experiences and perspectives on phenomena use the qualitative technique. If earlier concepts on a subject were underexplored, researchers employ a qualitative approach to gain a complete, in-depth understanding of the topic (Rutberg & Bouikidis, 2018). The purpose of the current study was to investigate

strategies that leaders of health care organizations use to manage workers from diverse ethnic and cultural backgrounds to increase performance. This subject was new; thus, a qualitative approach was suitable for in-depth analysis and development of a new concept.

Research Design

The design of this qualitative research was a multiple case study. Other qualitative designs considered were ethnography, grounded theory, and phenomenology (see Creswell & Poth, 2016). An ethnographic researcher uses observation and interviews to examine a cultural group (Creswell & Poth, 2016), which was inappropriate for the current study because I was not looking at cultural constructions. I also considered the phenomenological design, in which researchers identify the meaning of human experiences, and the narrative design, which is used to examine people's lives through their tales (see Creswell & Poth, 2016). However, I did not intend to make subjective interpretations of the participants' personal experiences in this study. A grounded theory study leads to the formation of ideas and hypotheses after gathering and evaluating data (Glaser, 2016), which was not in line with the purpose of my study.

A multiple case study was more appropriate than a single case study because, as Heale and Twycross (2018) pointed out, a single case study does not allow comparisons across different conditions in different firms. A case study involves a thorough and methodical examination of a specific phenomenon, person, group of individuals, or organization (Ridder, 2017). However, a single case study does not allow comparisons across different situations (Gustafsson, 2017). Therefore, I used a multiple case study

method with semistructured interviews to ensure I gathered data from several sources for comparison. In addition, a single case study would not have been sufficient to uncover the complexities of working in a racially and ethnically diverse environment in health care from multiple sources (see Gustafsson, 2017). The lack of practical solutions for managing health care workers from various ethnic and cultural backgrounds to improve performance necessitated a thorough investigation of several cases. Further, a multiple case study design helped me avoid having a personal bias during data collection.

Population and Sampling

The population for this study consisted of participants who are health care professionals, managers, and administrators in the state of Iowa with success in managing a culturally and ethnically diverse workforce. Qualitative researchers should select a specified sample of persons with defined features to ensure a study's credibility (Etikan, Musa, & Alkassim, 2016). Researchers employ sampling methods in a case study design to choose cases and data sources for an in-depth analysis of a phenomenon.

Nonprobability sampling refers to approaches in which the likelihood of a person or event qualifying for membership in the sample is uncertain (Etikan, Alkassim, & Abubakar, 2016). Nonprobability sampling can work in research studies in which the researcher's purpose is in-depth, idiographic comprehension rather than a general, quantitative comprehension (Etikan, Alkassim, & Abubakar, 2016). Nonprobability sampling can also be suitable in multiple case research with a qualitative approach (Etikan, Alkassim, & Abubakar, 2016). Researchers who want to contribute to social theories by expanding on or changing them can use nonprobability sampling techniques

to find situations that seem out of the ordinary to improve on existing topics (Etikan, Musa, & Alkassim, 2016). Different types of nonprobability sampling include purposive sampling, quota sampling, snowball sampling, and convenience sampling (Etikan, Alkassim, & Abubakar, 2016).

I used purposive and quota sampling to select the study participants and attain data saturation. Purposive sampling is a nonprobability method for identifying and selecting a sample in qualitative research. Purposive sampling is a method of selecting individuals with a lot of information based on their level of knowledge, experience, willingness to engage, and capacity to communicate about the topic of interest (Etikan, Musa, & Alkassim, 2016). When a researcher wants to include only persons who meet stringent criteria, purposive sampling is ideal (Etikan, Musa, & Alkassim, 2016). A researcher first decides which viewpoints they want to investigate to create a purposive sample and then seeks study volunteers who represent the entire spectrum of those perspectives.

In quota sampling, a researcher picks a category significant to the study in which there is likely to be some variation. Each type of sampling falls into subgroups, and the researcher decides how many persons or pieces of literature to include in each segment and then gathers data from the number selected (Etikan, Musa, & Alkassim, 2016). Although quota sampling has the advantage of assisting researchers in compensating for potentially substantial heterogeneity among study elements, it would be a mistake to believe that this method produces statistically representative results (Etikan, Musa, & Alkassim, 2016). I chose health care managers who met the eligibility requirements using

a purposive sampling method, while quota sampling was suitable for identifying literature for the research. The purposive sampling approach is suitable for finding participants who meet specific criteria (Etikan, Musa, & Alkassim, 2016). The criteria included health care managers in Iowa who had been leading a culturally diverse workforce for more than 5 years. Quota sampling helped me select cases from within several different subgroups related to culturally ethnic workforces (see Etikan, Musa, & Alkassim, 2016). The literature involved health care management practices, health care management successful strategies, and performance implications.

Researchers achieve data saturation during data analyses when they can no longer uncover new information or new themes, and there is commonality in responses from participants (Fusch & Ness, 2015). Data saturation occurs when no new themes, concepts, or findings are evident during the data analysis process (Saunders et al., 2018). I gathered data by interviewing participants and reviewing relevant organization documents. The interviews continued until there was no new information obtained and data saturation occurred.

Ethical Research

The chosen participants received an email asking them to consent to the study, with the disclaimer that doing so was voluntary. The names of the participants and all their personal information remained protected. Adhering to ethical principles in research can help prevent any direct injury or loss of privacy (Jeanes, 2016). Researchers need to consider and protect the well-being of the participants for ethical considerations (Wessels & Visagie, 2016). Before beginning the study, I obtained permission to conduct the

research based on the ethical principles established by the IRB approval 09-23-21-0375869. An IRB's principal responsibility is to safeguard the participants' rights (Miracle, 2016), and I ensured the participants' ethical protection as per the IRB's recommendations. The study included processes developed to protect and ensure participants' privacy during the study. There were no references to locations, addresses, or identities in the research findings. The study adhered to all norms of conduct. The *Belmont Report* identifies three fundamental ethical research principles: respect for people, nonmaleficence, and fairness (Friesen et al., 2017). I was honest about the study's goal, shared all relevant facts and hazards, supported participants' decision to participate or withdraw, preserved their identity, and upheld ethical standards to protect participants.

Because of the large number of human interactions between the researcher and the participant, qualitative researchers should develop and follow ethical rules. I contacted the participants through emails (see Appendix A) after I received consent to proceed with the study, inviting them to engage in the study using the email script (see Appendix C). A copy of the informed consent form was attached (see Appendix D). I informed the participants about (a) the study's goal, (b) the scope of their involvement, (c) any potential risks, and (d) their ability to withdraw at any time. The invitation included instructions on how to consent to the study. Participants provided informed consent by responding with the words "I consent" to the email invitation sent through my Walden University account or by signing the informed consent form before the start of the formal interview to acknowledge their consent to participate in the research. I clarified that participation is voluntary and that anyone can withdraw at any time.

The study did not include any of the data collected from participants who withdrew from the study. Following the interview and member verification procedure, all participants received an email expressing their gratitude for participating in the study. After publication of the study, I will provide a summary of the findings to the participants.

Researchers can protect the participants' identities through coding and can use codes to identify participants and remove any ties to personal identification (Kirilova & Karcher, 2017). I issued codes to each participant and organization, as Kirilova and Karcher (2017) recommended, to safeguard the identities of the individual participants and the organization. I identified the organization as Company X and the participants with the letter P followed by a number corresponding to the interview order. For example, participant codes were: P1, P2, P3, and so forth.

Throughout the research, I maintained all data gathered on a safe, password-protected, and encrypted storage system. Researchers must store all confidential material in a secure area (Kirilova & Karcher, 2017). For qualitative researchers, undertaking ethical research and respecting the privacy and anonymity of research participants is a primary concern (Jeanes, 2016). I kept all the obtained data in a storage cabinet in my home office for 5 years to protect the participants' and the organizations' right to privacy. When the 5-year storage period is up, I will shred all the paper documents using a local professional shredding company, and I will destroy all electronic data saved on the encrypted storage system using DBAN data-wiping software. I strived to meet all ethical considerations to ensure the credibility of the study.

Data Collection Instruments

I was the primary data collection instrument for investigating strategies that health care organization leaders use to manage workers from diverse ethnic and cultural backgrounds to increase performance. A researcher is the primary data collector in qualitative research (Mohajan, 2018), and researchers of qualitative case studies should use a minimum of two data-gathering methods. I collected primary data through semistructured interviews. I also collected secondary data through firm paperwork such as leadership reports, performance reviews, and strategic reports (Hagaman & Wutich, 2016). Mohajan (2018) pointed out that a semistructured interview can elicit participants' viewpoints and insights about a phenomenon. Researchers use semistructured interviews because of their flexibility that allows for minor deviations from the interview technique (Mohajan, 2018). Semistructured interviews allowed participants to go beyond the intended interview questions, which results in rich data. I also took notes during each interview.

I conducted semistructured interviews, as outlined in the interview protocol (see Appendix A) to collect data from 8 health care professionals, managers, and administrators, in the state of Iowa, with success managing a culturally and ethnically diverse workforce. Researchers use interview protocols to improve the effectiveness of the interview and to ensure they collect all relevant information within the specified duration (Amankwaa, 2016; Yeong et al., 2018). I asked each participant similar questions in the protocol (see Appendix A) with the same order and analyzed the data to identify emerging themes.

During the interviews, I collected data using Zoom software and two digital audio recorders as a backup device. I also reviewed publicly available documents from a deep probe into the two hospitals webpages. Using digital audio-recording devices allowed me to acquire data and improve my ability to transcribe verbatim comments from participants. I used Zoom digital voice recorder as the primary recording device and an Apple iPhone Xr and Sony PX-240 using an application for automatic transcription as the secondary recording device. I also recorded, with permission, the interviews I conducted via Zoom videoconferencing software using the software's in-built recording features.

Following the transcription of the interviews, I interpreted and summarized the responses of the participants. I set up a 20-minute follow-up appointment with each participant using Zoom videoconferencing software to review the summary and confirm my interpretation of his or her comments. Each participant read the summarized interview transcript and double-checked its accuracy. Member checking is a strategy used by qualitative researchers to ensure a study's credibility (Birt et al., 2016). Member checking can help to limit bias by validating and confirming the accuracy and authenticity of the participants' recorded experiences and opinions (Thomas, 2017). According to Hadi and José Closs (2016), respondent validation may be the most significant strategy for ensuring credibility in qualitative studies. Participants confirmed, explained, corrected, or added to their initial responses, ensuring the data's trustworthiness and authenticity.

Data Collection Technique

In qualitative studies, researchers use various data collection approaches to improve the study quality (Smith, 2018). I used semistructured interviews and document review to answer the study questions and meet the study aims. I contacted a total of 15 participants who matched the eligibility requirements through my social network friends, and 12 of them were interested in participating in my study. Three out of 15 were not interested in participating due to their work and family schedule. These participants volunteered on their own time, so I did not need permission from their employers. I reviewed the publicly available documents of the participant's organizations. Once receiving IRB permission to conduct the study, I emailed the participants and sent the informed consent form and an invitation to engage in a 30-45-minute semistructured interview through Zoom videoconferencing software. Four out of 12 did not return the informed consent. According to Castillo-Montoya (2016), semistructured interviews allow for correct content, coherence, legitimacy, and goal setting. A lack of procedure or a poorly designed protocol can result in erroneous data and a flawed study (Connelly, 2016). I used the interview protocol in Appendix A for coherence, legitimacy, and goal setting.

The interview protocol for qualified participants consisted of the following: an introductory statement and an explanation of the research background and aims, semistructured interviews, and a concluding remark. First, I scheduled a one-hour interview with each participant just in case, the participant might be late. The interview location was in the participant's work office, conference room, or home using Zoom

meeting software. I scheduled the date/time once I got confirmation from my participant. I emailed the participant the consent and request form to sign and return three days prior to the interview day. My participants complied to my requests promptly. I logged on to Zoom 15 minutes prior to the meeting to make sure Zoom software work. I greeted the participant, introduced myself as the researcher, and explained the study aims, confidentiality protocols, and instructions for withdrawing from the study during the opening statement and introduction. I also let participants know that they were volunteers and there were no incentives to participate in my research. I also notified each participant of the digital audio-recording devices or built-in recording capabilities in the videoconferencing software for the interviews. Next, I asked for permission to record participant responses and described the member-checking process. Finally, I began the semistructured interviews, which lasted 30–45 minutes.

I asked each participant the same sequence of questions to explore each response to each interview question methodically. According to Yeong et al. (2018), asking each participant identical questions ensures interview consistency and reliability. Amankwaa (2016) recommended that researchers maintain a degree of flexibility to facilitate deviations from the interview script through probes to obtain relevant, rich data. I probed participants with follow-up questions as needed to allow them to expand or elucidate their initial responses, ensuring the collected data were accurate.

I used two digital audio-recording devices to record the responses using Zoom software as the primary recording source and an Apple iPhone Xr and Sony PX-240 as a backup but did not get to use them. Audio transcripts allow researchers to collect

complex data and are rudimentary data analysis devices (Belotto, 2018). Member checking is a validation process that ensures data accuracy and increases the study's credibility (Birt et al., 2016; Spiers et al., 2018). I employed the member-checking technique after concluding the interviews. I also scheduled a 20-minute member-checking time slot with participants on the third day following the interview. I provided each participant with an electronic summary through email of their responses for inspection and validation. Participants was able to verify, confirm, amend, or supplement their original comments. I received participants electronic summary back within time slot scheduled.

Semistructured interviews as a data-collecting strategy have both advantages and disadvantages. Semistructured interviews are preferred as a data-gathering strategy in qualitative research because they are easy to organize and conduct (M. Johnson et al., 2017). Researchers can have access to in-depth participant viewpoints, thoughts, and sentiments by conducting semistructured interviews for data gathering, which results in rich and meaningful data (Boddy, 2016). In addition, semistructured interview forms give the opportunity and flexibility to deviate from the predefined protocol to obtain a thorough expression of your participants' thoughts and feelings (Clark & Vealé, 2018). Semistructured interviews also have some drawbacks, including lengthy transcription processes, dependency on the participant's capacity to recall material, and lack of control over the interview process by the interviewer (Yeong et al., 2018). My research interview appointments were within the timeframe scheduled between 30-45 minutes.

Data Organization Technique

Effective data organization is critical to qualitative research success. Researchers can include within their studies central data repositories with specific folders, database schema, and dates on a secure network site to store and organize collected data (Nowell et al., 2017). In addition, data categorization and management, including file and document classification and control, can help with data retrieval, research activity tracking, and data analysis efficiency (Castleberry & Nolen, 2018). I included a secure, password-protected network to store and arrange the data acquired from the semistructured interviews. I constructed two main folders for each data collection method using the naming convention interviews and health care facilities name. In addition, I associated my participant file name as same as their ID. For example, filed the name for participant 1 as P1. Last, each participant had a subfolder in the primary interviews folder.

Each participant folder contained the following items: (a) the signed informed consent form, (b) the raw audio recordings from the digital audio devices, (c) the interview transcript, (d) the tabulated interpretation for member checking, (e) the participant's member-checking responses, and (f) handwritten notes from the interview process. In addition, the organization documentation folder contained relevant information, including (a) strategic reports, (b) performance reviews, and (c) diversity reports. I maintained an electronic copy by scanning all hard copy documents of all collected data, and I added the file to the respective folder. I stored all hard copies in manila folders with the corresponding naming convention as the electronic file format. I

kept the hard copies in a personal filing cabinet accessible to me alone. Researchers must save all obtained data in a secured and secure storage system to preserve each participant's anonymity and safety (Friesen et al., 2017; Kirilova & Karcher, 2017). A closed cabinet in my home office held all collected electronic and hard data copies and remain accessible only to me for five years, after which I will destroy them following the appropriate protocols.

Data Analysis

The aim of conducting a qualitative multiple case study is to explore concepts, experiences, and opinions relevant to the study topic (Yin, 2018). Qualitative data analysis involves determining major themes emanating from the data collected and connecting the main themes with the study thematic areas. In this case, the approach involved coding the data collected and aligning the coded information to the study thematic areas. Coding data involves transforming collected information or observations into a set of meaningful, cohesive categories that includes summarizing and re-presenting data in order to provide an accurate account of the observed phenomenon (Elliott, 2018).

Several qualitative analysis methods are suitable for application in any research. Researchers can consider the various qualitative analysis approaches and choose the most appropriate approach for the research (Levitt et al., 2021). The approaches include narrative analysis, text analysis, notes analysis, and thematic analysis. The most precise and widely used qualitative analysis approach is thematic analysis, which researchers can use to connect emerging themes to a thematic area. The present analysis included thematic analysis and largely depended on the coding system noted earlier.

Thematic analysis is a type of qualitative data analysis that researchers apply to texts and is often the most robust and adequate analysis method applied in a study (Maguire & Delahunt, 2017). In most cases, researchers apply thematic analysis to interview transcripts, which provides respondents' perception and opinion about the topic of interest. The present research included in-depth interviews with participants to seek their perceptions and experiences in relation to the topic of study. I audio recorded and transcribed the interviews to allow for robust coding and thematic analysis. When using thematic analysis, researchers are keen to identify common topics, ideas, and patterns across the responses and align them with the major thematic areas of the study. The study included three major coding components when analyzing the transcripts thematically: descriptive codes, emotional codes, and NVivo codes (Maher et al., 2018; Rogers, 2018). There are variety of qualitative data analysis software. I compared the pros and cons between NVivo and Atlas.ti. I found Atlas.ti software was cheaper than NVivo, however, NVivo supports academic, professional, student researchers in education. In addition, I have used NVivo previously and found it user-friendly.

NVivo is one of the software recommended by Walden University. NVivo uses for the analysis of unstructured text, audio including interviews, focus group, and survey (Zamawe, 2015). I used NVivo codes or the verbatim expressions of what the participants say during the interview, to bring out the core opinion among participants. After creating the codes in the categories identified, I engaged in reviewing the codes with the aim of analyzing and identifying patterns that derive from the codes across the transcripts. This

NVivo software enabled me to reveal major themes arising from the codes while also aligning the themes with the key research questions.

In thematic analysis, codes exist that potentially present themselves as themes, and as such, I left them with the NVivo software version 12 to make the analysis more robust and explorative. After developing themes from the codes, the next step was to review the developed themes to ensure they are accurate and representative of the data collected. This NVivo software involved comparing the developed themes against the data collected to determine if there is any variable or information missing from the themes or considered appropriate for the analysis. I then sought to determine whether these themes demonstrate consistency with the research topic.

The conceptualization of coding in the thematic analysis was embedded within my decision making with the intent of aligning with the research purpose and research questions. I made decisions about the codes in relation to the density and frequency of wording and phrases, as well as the amount of the data to analyze. I made these decisions in consideration of the research background and the design used in this study. I applied ethical considerations to protect the confidentiality and well-being of the participants during the data collection process and to ensure reliability and validity through triangulation, member checking, and reflexive journaling.

Reliability and Validity

To have study findings that are practical and can be used, it is important to ensure the research quality. Consequently, the quality of a research project often relies on the data collected. Therefore, it is important to ensure that the tools used in data collection

are robust in measuring the research questions outlined, while also ensuring alignment with the research purpose and objectives. Researchers can only achieve this quality of a research project through ensuring the reliability and validity of the tools used in the study. These reliability and validity are concepts used by researchers to evaluate the quality of a research study (Noble & Smith, 2015). Researchers illustrate how the techniques and methods applied in a research study are accurate, including the test measurements.

Researchers seek to establish rigor when conducting their investigation. Rigor, in qualitative terms, means establishing trust or confidence in the findings of a study, and it allows researchers to establish consistency in the methods used. Rigor refers to the state of confidence or strength in the research design, the carefulness of the research method, the thoroughness of the data collection process, and the accuracy of the interpretation (Cypress, 2017). The two fundamental concepts within the qualitative evaluation process to establish rigor are reliability and validity (Connelly, 2016).

Reliability

Reliability refers to how the measures used in a research study are consistent, and validity defines the accuracy of the measures used in a research study (FitzPatrick, 2019). My research had measures in place to ensure the integrity of information gathered and the findings. This qualitative research study included measures of cultural diversity to ensure the credibility of the information therein.

Quantitative studies often rely on statistical methods to ensure the validity and reliability of research studies (McDonald et al., 2019), but this research was qualitative,

and as such statistical approaches are not suitable. Researchers have defined strategies to ensure the data collected are accurate and reliable for decision making or for practical implications. The strategies used to ensure reliability and validity in this research largely focused on the methodology and research design employed.

Validity

Validity refers to the trustworthiness and credibility of findings (Hayashi et al., 2019). Biases in a study often influence the findings. In this case, I developed the research design in a robust manner to reduce or eliminate any bias that may occur and the resultant influence on the findings. This process involved ensuring equal representation of gender participants in the study. I also ensured that every eligible participant had an equal opportunity to participate. The participant selection ensured the representation of all demographic traits occurs in the study and potential participants had an equal chance of participating rather than selecting individuals based on personal judgment. The second approach to ensure validity and reliability in this study were through engaging in meticulous record keeping. Such record keeping provided a clear trail on the process of making decisions from data collection approaches to data analysis and reporting.

As the study involved using codes to identify patterns and major themes emerging from the data, the codes were primarily embedded in the researcher's judgment and decisions. The important in research is to keep records on the decision-making process and to evaluate whether there was any bias. The study also involved making determine any similarities or differences across accounts, such as differences perspectives cultural diversity based on gender, education level, or age. This comparison helped to ensure the

representation of all the different perspectives in the analysis. The analysis included a rich verbatim description to support the findings. I achieved such descriptions through NVivo coding, which involved coding participants' perceptions verbatim. The research included eight health care leaders and managers from two large hospital facilities. Such consultations helped to ensure the study includes a variety of thought processes to reduce any bias that may occur.

Transition and Summary

In Section 2, I restated the purpose of this case study and provided information regarding the role of the researcher, the study method, the study design, the selection of study participants, and the population and sample size. I elucidated how I planned to achieve data saturation; to ensure the application of ethical considerations to protect the confidentiality and well-being of the participants during the data collection process; and to ensure reliability and validity through triangulation, member checking, and reflexive journaling. I outlined the data collection instrument, the data collection and organization techniques, and the data analysis process using methodological triangulation.

Section 3: Application to Professional Practice and Implications for Change

Introduction

The objective of this multiple case study was to investigate strategies that health care organizations' leaders employ in the management of workers from diverse ethnic and cultural backgrounds for performance. I collected data from semistructured interviews with eight health care professionals, managers, and administrators from two health care facilities in Iowa with experience in managing a culturally and ethnically diverse workforce. Using the cognitive diversity theory (see Amabile et al., 1994) as the study's conceptual framework, I explored the strategies these leaders employed within the selected facilities, including their experiences regarding the success of these strategies and recommendations for improvement. The participants highlighted multiple strategies that included targeted commercial advertising, recruitment, referral bonus programs, flexible work schedules, and promoting organizational goals surrounding cultural diversity.

The strategies to maintain diversity highlighted by the participants included an annual employee engagement survey, scheduled rounding with their leaders, Socratic questioning to broaden student perspectives, essay reviews, review of student submissions from nursing and allied health programs, and individual feedback. Other strategies included team teaching, consultations, annual employee surveys, an anonymous see-something-say-something program, staff assistance, and opportunities to share individual perspectives. Section 3 comprises the presentation of findings, application of

results to professional practice, implications for social change, recommendations for action and further research, reflections, and a conclusion.

Presentation of Findings

This qualitative multiple case study was conducted to answer the following research question: What strategies do leaders of health care organizations use to manage culturally diverse workers and therefore increase performance? To answer the research question, I reviewed each company's diversity polices and conducted semistructured interviews virtually using Zoom videoconferencing software and the software's built-in recording features. The interviews were conducted virtually to ensure adherence to the World Health Organization protocols to prevent the spread of the virus. In line with the multiple case study approach, I conducted the interviews with participants from different institutions with different leadership's positions. Participants comprised health care professionals, managers, and administrators within the state of Iowa who had successfully managed a culturally and ethnically diverse workforce. The participants were drawn from health care organizations that were also learning facilities. These facilities are reputable, accredited, and recognized organizations within Iowa and have quality care programs of international standards.

Eight leaders were interviewed who were health care professionals, managers, and administrators from the selected organizations. The criteria for participants' selection included health care leaders in Iowa who had been leading a culturally diverse workforce for more than 5 years. The criteria for literature selection involved considering health care management practices, successful strategies, and performance implications. The

participants were invited via email requesting their consent to participate in the study. The email had a disclaimer that participation in the study was voluntary. Among 15 leaders who were invited, 12 agreed to take part in the study. Four out of 12 did not return the informed consent form. Interviews lasted 30–40 minutes. I transcribed the recordings between interviews. I also reviewed publicly available documents from a deep probe into the two hospitals' webpages. To ensure each participant's confidentiality, I identified them as P1, P2, P3, P4, P5, P6, P7, and P8.

All participants were involved in the management of a diverse workforce within their institutions through recruitment, training, and/or policy development and implementation. Thematic analysis was employed, and the data collected were analyzed until data saturation was attained with no new themes emerging. The thematic analysis of transcripts included descriptive codes and NVivo codes.

The interviews were recorded using multiple devices. Zoom was used for virtually conducting the interviews. The recording was through the Zoom application recording feature. In addition, I used digital recording devices, specifically Sony PX-240 and an Apple iPhone XR, as a backup. All of the participants responded to six open-ended interview questions as provided in the interview protocol (see Appendix A) to ensure consistency and reliability, with each interview lasting between 30 and 40 minutes. The participants shared their perspectives and experiences regarding the strategies they employed in the management of a diverse workforce based on the positions they held. Participants also provided recommendations on the strategies they perceived could be used to improve the management of diverse workforces.

At the end of the interviews, I thanked each participant for consenting to be part of the study and the contributions to the research and practice. Later, I transcribed the recorded data and sent each transcription to each participant via email to confirm whether what was transcribed was what they said during the interview. After transcription, I also conducted member checking via email on the third day after the interview, where each participant was given a paragraph of the created interpretation for each response to the interview questions. The objective was to establish the validity and reliability of the interpretation from the participants' perspective. The process allowed the participants to provide additional information, material, and resources on the subject. The participants did not apply any additional information or make changes that significantly contributed to the attainment of data saturation.

Conducting case study research involves engagement in the process of data triangulation. The process consists of collecting data from multiple sources, for instance through interviews, participant observations, and archival documents and records (M. Johnson et al., 2017). In addition to interview data, I reviewed publicly available documents from a deep probe into the two hospitals' webpages regarding diversity policies.

Following data collection, I used Yin's (2018) five-step process of qualitative data analysis. The steps were compiling, disassembling, reassembling, interpreting, and concluding. This began with the transfer of the information collected into Microsoft Word through manual coding and analysis of the data to determine the key themes. These

data were then transferred into the NVivo software for qualitative analysis to provide computer-aided coding, interpretation, and development of the relevant themes.

I evaluated the themes generated by the NVivo software and the manual processes of data analysis. The evaluation generated five themes: (a) leaders used recruitment strategies promoting diversity, (b) leaders encouraged and used communication/feedback, (c) leaders conducted diversity training to encourage diversity, (d) leaders provided suitable working conditions to promote diversity, and (e) leaders encouraged and engaged in teamwork and collaboration. Each of these themes validated the primary themes inherent in the study's reviewed literature.

When physical diversity is created in relation to race, age, or sex, individual performance is positively affected (Kerga & Asefa, 2018; Stamarski & Hing, 2015). P1's response suggested that diversity is promoted by employing diversity-focused recruitment strategies such as targeted commercial advertising and, post COVID-19, offering targeted job fairs to expand the representation of diversity in the organization. Similar strategies were reported by P5, who indicated that they sourced for a diverse workforce from different forums. The participants reinforced the cognitive diversity theory and research tied to the theory. Although cognitive diversity theory provided different strategies and experiences, they were all targeted at promoting and ensuring diversity within the organizations. The multiple case study approach provided diverse responses (see Table 1).

Table 1

Coding of Participants' Responses Related to Themes

Theme	Participant[a]	Response[b]
Recruitment strategies promoting diversity	3	1
Encouraged and used individual communication/feedback	8	5
Conducted diversity training to encourage diversity	4	4
Provided suitable working conditions to promote diversity	8	6
Encouraged and engaged in teamwork and collaboration	4	5
Total	27	21

Note. [a] Number of hospital leaders who contributed responses linked to the themes. [b] Number of interview questions for which participant responses related to the themes.

Theme 1: Leaders Used Recruitment Strategies Promoting Diversity

The participants reported that their organizations employed recruitment strategies that ensured they acquired a diverse workforce. The leaders within health care organizations are required to use recruitment and employment strategies that promote organizational diversity, which alludes to engagement in diversity management (DM). The recruitment of a culturally diverse workforce increases the opportunity for strengthening organizational goal attainment through the inputs from persons with diverse thought patterns (Mello & Rentsch, 2015). During recruitment, leaders can create cultural barriers restricting cognitive diversity through biases, such as race/gender and worldviews.

P1, P2, and P7 suggested that by employing the appropriate employment and recruitment strategies, organizations can acquire diverse personnel as a strategy of managing diversity within organizations. Specifically, P1 reported that their organization

used various marketing techniques, including commercial marketing, in their recruitment. The participant also added that their organization is targeting expanding these efforts after the COVID-19 period and offering targeted job fairs as a strategy for increasing the representation of diversity within their organization.

P5 reported that she actively sought out diversity, equity, and inclusion (DEI) and equal employment opportunity staff. She further added that she considers where she would have the best interactions with persons at the community level who would join their workforce and interacts with them through community groups serving their ethnic and cultural identities. For instance, professional groups for Black, Indigenous, People of Color, LGBTQ, refugee support services, advocacy groups, and schools. Finally, P7 reported that she ensures all potential employees understand that diverse perspectives and opinions are welcome during interviews. A review of the policies revealed that diversity creates a stronger feeling of inclusion and community for health care workers, which makes the workplace feel safer and more enjoyable.

The findings supported the reviewed literature. DM in the workplace has been described as a working environment valuing each unique aspect every individual brings to the organization (Samuel & Odor, 2018). The adoption of DM is the organization's commitment to recruit, select, reward, promote, and retain a diverse composition of employees at any particular point in time (Samuel & Odor, 2018). As Karamitri et al. (2017) noted, in the context of DM, health care organizations' management includes the efficient recruitment of qualified employees, efficient running of the organization and its departments, the attainment of specific outcomes, and the proper use of resources. These

are considered elements of DM. Abaker et al. (2018) highlighted that the beginning of DM is adopting policies within health care facilities having a direct/indirect impact on how people treat each other. Therefore, such recruitment strategies are part of DM strategies employed by the leaders, as indicated in their responses. In reviewing the policies of the health care facilities, I noted that diversity is used as a hiring strategy. Both facilities seek employees with bilingual abilities to fill key roles in their organizational leadership. The rationale is that this will promote equity, respect, and cultural awareness for the communities they serve.

Theme 2: Leaders Encouraged and Used Communication/Feedback

Communication and feedback, either alone or in combination, were established as among the primary strategies for DM within participants' health care organizations. Communication has been identified as a cultural barrier. Lott and Abendroth (2019) highlighted that the challenges emanate when employees use different languages, gestures, behaviors, and symbols while communicating. Midgley et al. (2017) noted that because people come from diverse backgrounds, they are likely to misinterpret/misunderstand communication between each other.

The participants recognized the importance of using communication as a strategy for managing diversity within health care organizations. P1 reported that the organization used surveys as a means of acquiring feedback on the facets of the organization. The participant further stated that the organization encouraged many forms of diversity in thought and suggestions regarding its operations. Similarly, P3 and P5 reported that they also used surveys to elicit individual feedback, with the latter indicating the surveys were

conducted annually. Some of the annual surveys included ethnic and cultural identity information that helped in information filtering to establish whether the organization was acquiring multiple perspectives.

P2 reported that she employed Socratic questioning to broaden student perspectives. A similar approach was used by P3 to gain information from employees, including examples/evidence for supporting the current perspective. The participant further indicated that they asked questions and offered positive feedback without minimizing every differing point. In addition, P2 reported reviewing essays that are biased toward a specific profession or presume that the reader is of a similar profession. She reviewed student submissions from nursing and allied health programs, including dental, dental hygiene, respiratory therapy, occupational therapy, physical therapy, radiology technician, psychology, and paramedic. She also added that she "welcomed the students' perspectives, especially when I read about different cultures, whether that be Polynesian cultural influences in Hawaii, Native American cultural beliefs, or Torres-Straight Islanders culture in Australia." P3 also used weekly check-ins to acquire feedback and provided message boards where employees could share their opinions and comment on opinions provided by others. P3 added that she offered room for debating the different perspectives expressed among the employees to acquire perspective.

P4 reported that they ask questions from workers on the position of student/faculty issues. The participant also indicated that they had monthly departmental meetings and would share opinions and provide feedback regarding teaching instruction or lesson plans. She added that she used open-ended when communicating with

coworkers and encouraged them to share their past teaching experiences with students and other facilities. She wants her coworkers to talk to other faculty and employees in areas they work in regarding the need to share ideas with each other, a strategy that P6 also employed. P5 indicated that she seeks information through face-to-face meetings, email, virtual meetings, town halls, and unit meetings. P5 seeks information regarding challenges in the department by asking whether there are safety/ethical concerns, including opportunities for improvement daily. P5 reported that the organization has an anonymous "see-something-say-something" program allowing employees to submit concerns, questions, and celebrations if they are uncomfortable speaking directly. P5 added that the organization has workplace groups for employees from multiple ethnic and cultural identities, which assists in developing a sense of connection. Moreover, the employees can directly access the equal employment opportunity staff who help in soliciting input and feedback. P5 also facilitates the principle of "seek first to understand, then to be understood."

P7 allowed everyone to share their opinions and ensure that every person understood that there is no single approach to doing things. Finally, P8 highlighted that they discussed the community, including the racial issues that have been persistent in the community. The participant added that the academic environment at Des Moines Area Community College (DMACC) encouraged respectful communication for discussing diversity in the classroom, which demonstrated the value placed on diversity and elements that the faculty was required to portray in the classroom. The participant also

reported that she believed in maintaining open communication and addressing any emerging issues.

The findings based on the participants' responses support the findings on the discussed and reviewed literature. Ahmad and Rahman (2019) highlighted that organizational problems become magnified when individuals are unwilling to discuss diversity-related issues openly. They further indicated that the most appropriate strategy for promoting and managing diversity in the workplace is establishing two-way communication (Ahmad & Rahman, 2019). The communication, however, should be friendly and respectful, and the communicating parties should be willing to prevent an escalation (Ahmad & Rahman, 2019). Cletus et al. (2018) highlight that diversity training (discussed further in the next section) facilitates positive communication between groups. This is indicative of the importance of communication and feedback in DM. Okoro and Washington (2012) highlighted that an effective approach to DM is one that promotes effective organizational communication. According to Chua et al. (2015), the rationale is that diversity strengthens the relationship between the organization and a specific group of customers by increasing communication effectiveness.

P5 reported that their organization did not have a diverse workforce; therefore, they lacked the opportunity of tapping into diverse perspectives. This is among the risks of lacking diversity in an organization and highlights the need for DM within health care organizations (Goode & Landefeld, 2018). Kabisch et al. (2015) also noted that a lack of diversity was indicative that a health care organization will have limited perspectives. As identified by Gopalkrishnan (2018), the limitations are when interacting with each other

and during the provision of medical care, psychological treatment, and social support. Croucher et al. (2015) also noted the limitation in perspective resulting in communication breakdowns emanating from language barriers, varying philosophical perspectives and approaches to care provision, different cultural norms, expectations, or cultural biases. Vardaman et al. (2020) noted that limited view hampered creativity and innovation, including missing critical information when diagnosing, history taking, and considering other determinants of an individual's health and well-being. A review of company policies revealed that the administration does not tolerate discriminate toward its employees and patients on the basis of age, race, ethnicity, religion, culture, language, and etc. The leadership creates two-way communication between their administration and team members to value team member input from all team members.

Theme 3: Leaders Conducted Diversity Training to Encourage Diversity

According to Di Fabio (2017), the failure to provide diversity training is risking losing the organization finances, including incurring additional costs for replacing employees. Diversity training is deemed a direct approach to DM, with the most suitable context for promoting and addressing diversity-related issues being by establishing an organizational culture that embraces diversity (Maj, 2015; Patrick & Kumar, 2012). Cletus et al. (2018) define diversity training as a program designed to facilitate positive intergroup communication, collaboration; decrease prejudice and discrimination from one to another. Diversity training is among the most effective means of DM and reduces health care facilities' associated conflict (Cletus et al., 2018). Participants 2, 4, 7, and 8 reported diversity training as a strategy employed within their organizations.

P2 stated that her role was broadening the students' perspective regarding other cultures and fostering cultural awareness development as an educator. P5 said, "One question can result in a student considering a new perspective or approach." In addition, the participant indicated that as an employee in a multinational company, they complete annual modules that contain a thread of cultural diversity which reinforces the concept as part of the organization's culture. P4 reported that the organization has a Licensed Practical Nurse (LPN) training program established two years back, and the organization works with Boone and Urban campus faculty. According to the participant, these programs offer an opportunity for incorporating diverse ideas from others and collaboration with different campuses with varying perspectives. As part of the organizational culture, faculty from various departments have collaborated to build the program. She also reported that "Faculty Development Days include all faculty from our organization, and there is usually a topic that fits with cultural diversity and inclusion". P7 indicated that as part of training, the counseled employees from diverse perspectives on how certain, for example, certain comments and behaviors can be perceived as disrespectful by others. Finally, P8 indicated that the institution (DMACC) had purchased education and training modules: Bridges out of Poverty by Payne, DeVol, and Dreussi Smith. These provided vital starting points to assist in understanding vulnerable populations, particularly poverty, middle class, and wealth which helps learners understand the vulnerable groups and why they often do not adhere to the prescribed orders.

The participants' responses are in tandem with the reviewed literature of the study. Cletus et al. (2018) highlighted that training programs on diversity facilitated positive communication and collaboration between groups. Such training also diminished intergroup discrimination and is the most effective technique for DM and reducing conflicts within health care facilities (Cletus et al., 2018). Further, the training is modified to allow employees to undertake their roles within a diverse work environment (Cletus et al., 2018). For instance, health care facilities help employees learn about the differences and similarities within each other employees (Cletus et al., 2018). The training involves teaching both genders to work with each other effectively and efficiently and provides insights into how others understand individual behaviors (Cletus et al., 2018). An example is the employees' perception that some behaviors evoked by male managers are sexist (Cletus et al., 2018). Further, teaching female employees will allow them to verbalize behaviors from the managers they consider uncomfortable without being hostile (Cletus et al., 2018). The training may help persons from different races understand each other. A review of company policies indicates that each health care facility creates an education environment, mentoring, networking, and supporting all employees. One facility provides a communication system where an interpreter for sign language and non-English speaking patients is available at all times.

Theme 4: Leaders Provided Suitable Working Conditions to Promote Diversity

DM within the workplace is considered a process involving creating a work environment valuing everything an individual brings to the table as being unique. The objective is blending unique cultures, the implication being proactivity by all an

organization's members to respond effectively to challenges inherent in working in diverse groups (Samuel & Odor, 2018). Therefore, DM does not mean leaving the situation where you feel uncomfortable but learning from the situation.

All the participants reported the provision/creation of conducive working environments as a DM strategy. For instance, P1 stated that they work with other managers and administrators to solve employee problems and are working on building DEI in their daily work. The objective is to integrate every DM strategy in the facility and will assist the organization's bottom line through the alignment of Health Equity measures offering compensation with the quality metrics used at the facility. These strategies will improve the company's cash flow into the organization and assure that the patients receive the highest quality of care. P2 stated, "They promote cultural awareness and encourage cultural diversity," while P3 indicated they have Referral bonus programs that offer "flexible schedules that can provide a good work/life balance. Promoting the organization's goals surrounding cultural diversity." Participant 3 further added that a culturally diverse organization provides changes in perspective regarding how education is delivered and accepted and has hired a "Chief Diversity Officer" to assist in creating and maintaining a diverse work environment. P8 reported that the institution provides diversity workshops for adjunct faculty and all new faculty. DMACC's work environment promotes respectful communication for diversity discussion and demonstrates the value of diversity that should be demonstrated in class.

The findings support those established by Abaker et al. (2018), who indicated organizational practices promoting diversity include those that create networks of

different groups managed by leaders and managers. In addition, the primary attribute of organizational diversity is multiculturalism through the adherence to flexible policies and procedures (Abaker et al., 2018). These policies and procedures are, for example, benefits packages, such as insurance, that can accommodate personal situations (Simons & Rowland, 2011). Simons and Rowland (2011) highlights that organizations with leaders intending to promote diversity are obligated to mold the organizational culture to include the top management's commitment to supporting all forms of diversity within the organization. The policy review revealed a commitment to improve working conditions, that are safe and benefits diverse groups. Both organizations comply with applicable Federal civil rights laws and do not discriminate on the basis of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. Explicitly stated, these organizations do not exclude people or treat them differently because of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression.

Theme 5: Leaders Encouraged and Engaged in Teamwork and Collaboration

As indicated by Cletus et al. (2018), a component of diversity training involves designing programs facilitation collaboration. Some participants reported using a DM strategy involving teamwork and collaboration at the individual or organizational level. For instance, Participant1 said, "We work as a team and in a team atmosphere so we value all opinions from our teammates." The participant added that they work with other managers and administrators to help solve diversity problems among employees. P3

stated that she is heavily reliant on staff to contribute innovative ideas. P4 reported that she felt nice being placed with different people who teach other topics besides nursing as they are a unique department that fends for itself. P5 suggested that "…DEI consideration should be included in all levels of leadership decision-making and strategic planning."

The findings support the reviewed literature where Liao and Long (2016) and Torchia et al. (2015) established that DM involves bringing together cognitively diverse teams and such teams have better performance regarding team collaboration and performance. The rationale is that such teams can access multiple perspectives, which can be minimally accessed by teams that lack such diversity (Liao & Long, 2016; Torchia et al., 2015). Nair and Adetayo (2019) also established that access to diversity would result in more effective and efficient work and collaboration of a diverse team of health care providers. Khanam et al. (2020) established that persons with almost similar attributes tend to work together more effectively within the organizational setting. DM has also been found to create a diverse working environment and teams as employees are exposed to different cultures, ideas, and perspectives (Ekwochi, 2018). Stated in the hospital policy of facility one: Leadership commits to build a respectful workplace, an open and inviting environment to all employees, patients and families.

Findings Related to the Conceptual Framework

The study employed the cognitive diversity theory to explore the strategies that leaders in health care organizations use to manage culturally diverse workers and therefore increase performance. The underlying principle inherent in the theory is that having a diverse workforce with multiple perspectives originating from the cultural

differences among groups or the members of the organization results in creative problem solving and innovation (Mello & Rentsch, 2015). In addition, a culturally diverse workforce provides opportunities for strengthening goal attainment through inputs from persons with diverse thought processes (Mello & Rentsch, 2015). The fundamental reasoning is that organizational leaders should be able to address group-think by bringing people who think in different ways together to eliminate functional bias and low cognitive diversity for performance improvements (Meissner & Wulf, 2017).

The participants confirmed the cognitive diversity theory. For instance, P1 reported that by working with other managers and administrators with cognitively diverse thinking, they could solve any emerging problems. The participant further added that by building DEI, they would be able to integrate it in every organizational strategy and will help their bottom line by "…aligning Health Equity measures that offer compensation with our Quality metrics that we presently use." According to this participant, the outcomes will be improving cashflows and ensuring the provision of the best quality care. P3 also reported that their bottom line had been positively affected by implementing cultural diversity in the organization. P4 highlighted that by learning the culture of their students and accommodating their needs to improve access to education and improve retention rates. The five themes generated in this study highlight the strategies health care organizations'' leaders use for DM to improve performance: (a) leaders used recruitment strategies promoting diversity, (b) leaders encouraged and used communication/feedback, (c) leaders conducted diversity training to encourage diversity, (d) leaders provided suitable working conditions to promote diversity, and (e) leaders encouraged and engaged

in teamwork and collaboration. P5, highlighting the adverse effects of the lack of diversity, indicated that having significantly homogenous groups creates narrow-minded thinking, and the organization misses out on the opportunities that come with broadened perspectives.

Applications to Professional Practice

The specific problem that this study was founded on is that some health care organizations' leaders lacked sufficient strategies for managing employees from diverse ethnic and cultural backgrounds to increase performance. As discussed above, the study's findings highlight the strategies leaders in health care organizations in Iowa employ in the management of workers with diverse ethnic and cultural backgrounds for improved organizational performance.

The findings are applicable in ensuring the maintenance of a diverse organization and leveraging on the diversity to improve organizational performance: financial and care provision. The results offer suggestions for hospital leaders to improve DM where the objective was improved performance: used recruitment strategies promoting diversity, encourage and use communication/feedback, conduct diversity training to encourage diversity, provide suitable working conditions to promote diversity, and encourage and engage in teamwork and collaboration. As Raewf and Mahmood (2021) highlighted, appreciating cultural diversity was critical for eliminating negative stereotypical beliefs about certain cultures, promoting fairness, and ensuring equality in an organization. The social change implications identified the possibility of these leaders to maintain organizational harmony, and the hospital continues to have positive economic impacts

within their community, including improving the quality of care provided (Raewf & Mahmood, 2021).

The findings are pertinent to improved workplace diversity and organizational performance and are in line with some of the reviewed literature, such that by Inegbedion et al. (2020), who established that the application of the DM strategies improved productivity and creativity and profitability. Other researchers acknowledged that greater diversity increased organization performance due to improved innovation and creative problem solving, including decision making (Ahmad & Rahman, 2019; Chua et al., 2015; Duchek et al., 2019; Mulu & Zewdie, 2021; Younis, 2018). Other researchers established that DM ensures the attainment of the maximum potential and contribution to the organization while maximizing the advantages and minimizing the disadvantages of a lack of diversity (Olsen & Martins, 2012; Patrick & Kumar, 2012).

The earlier study by Kim (2006) noted that diversity management is driven by corporate strategy and mission, which offers a unique advantage to an organization when flexibility and creativity are critical to competitiveness. Urbancová et al. (2020) acknowledged that health care organizations consider DM as a source of competitive advantage and that DM promoted employee retention, improved performance and motivation of current employees, and improvement in the organizational atmosphere. Ekwochi (2018) established that creating a diverse work environment allows personal growth, as employees are exposed to different cultures, ideas, and perspectives. Such an environment also enabled individuals to develop clear insight regarding their position globally and enhance their immediate surroundings (Ekwochi, 2018)., when such

employees spend time together, they break through existing barriers to become more experienced persons within the community (Ekwochi, 2018). Ahmad and Rahman (2019) established that uniting diverse skills and knowledge from individuals with different cultural backgrounds can significantly positively affect a company. This may strengthen the organizational responsiveness and productivity and allow change adaptation (Ahmad & Rahman, 2019).

Finally, DM was also recognized as significantly influencing an organization's efficiency and enriching institutions by sharing different perspectives with workmates and colleagues (Inegbedion et al., 2020; Shepherd et al., 2019). Overall, DM strategies enhanced the implementation and outcomes of the principles of health management: the unity of command (Al Mosawi, 2019; Bacud, 2020), equity (AlJaberi et al., 2020; Bacud, 2020), team spirit (Nobus, 2016), work division and discipline (Bacud, 2020), authority and responsibility (Chandler et al., 2016), and individual interests' subordination (Moyo et al., 2016), to mention a few.

Implications for Social Change

The application of these findings may have broader social effects. The implications for positive social change include the potential for health care leaders to build a more inclusive culture that can lead to lower turnover in staff and improve the quality of healthcare for patients. Among the effects that have been identified in the reviewed literature are ensuring effective organizational communication by strengthening the organization's relationship with a specific group/population of customers (Chua et al., 2015; Okoro & Washington, 2012). Chua et al. (2015) noted that among the critical areas

affected by DM is customer service, as it ensures employees are paired with customers from certain areas or locations who then feel at home. In addition, Grandpierre et al. (2018) established that diversity in the health care context goes beyond the language barriers and requires the comprehension of a patient's mindset in the broader context of culture, gender, sexual orientation, religious beliefs, and socioeconomic realities, which is achieved through DM. Better diversity in health care organizations is an effective way to address the barriers that service users experience while seeking care and contributes to improvements in the quality of care provided (Cletus et al., 2018). Health care providers are required to provide and teach global competence in health care provision, which allows students to transfer such knowledge to health care organizations ensuring they can care for a diverse population (Flynn et al., 2020). M. Johnson et al. (2017) also established that DM allows health care providers to provide customized care that acknowledges and recognizes individual differences among different populations. In addition, DM has increased accessibility to health care education, and encouraging a broad range of applicants is critical to reducing any higher education barriers (Nair & Adetayo, 2019).

Recommendations for Action

DM has been described as strategies involving the development of business practices to promote an inclusive workforce to improve organizational performance (Samuel & Odor, 2018). Developing a conducive diverse environment is the objective of workplace diversity (Samuel & Odor, 2018). From the study's findings and literature reviewed, leaders are responsible for ensuring the organizational environment promotes

diversity in growth and thinking in its health care practices and education. To promote innovation, creativity, and awareness of diversity, the leaders should include diversity training as part of the organizational culture to attract and retain diverse talents and teams. This study has revealed multiple strategies for developing and managing organizational diversity to support individual and organizational growth.

Based on the findings, my recommendations for health care organizations' leaders and other practitioners on diversity in the efforts to encourage and improve DM practices include: (a) the implementation of programs focused on diversity to promote an organizational culture of inclusion, mutual respect, and equality in their interactions with others in the workplace to encourage effective collaboration and productivity between teams, (b) emphasize awareness on diversity-related issues using formal and informal communication channels, such as social media to enhance the understanding of the importance of the organizational teams and inclusive practices as part of the organizational objectives among employees and other key stakeholders, (c) conduct advertisements on management policies on diversity on the organizations' website which underscore their commitment to workforce diversity to ensure operational sustainability, and (d) provide diversity training, for instance diversity workshops, unconscious bias, and panel discussions that cover contemporary issues on diversity and to promote organizational learning and experience among employees.

Moreover, (e) set up recruitment strategies targeting diverse groups to increase the representation of diversity regarding gender, ethnicity, and skills. The rationale is that diverse thinking improves health care delivery that meets the care needs and demands of

the diverse population of health care consumers. Next, (f) develop diverse organizational goals, including goals for other stakeholders to ensure diversity practices reflect the customers base of the organization and support the communal activities, (g) encourage and engage leaders and managers in each level and department of an organization to practice diversity and offer inclusive leadership to promote organizational change and improve performance, (h) build strategic partnerships with different internal and external stakeholders for enhancing workplace diversity by using diversity groups and/or counsels, including governance groups, and (i) incorporate diversity management tools, for instance, a scorecard, dashboard, and surveys to display commitment, accountability, and transparency to the health care organizations' practices and strategies.

The findings in this study could offer a helpful resource to leaders in healthcare organizations, including diversity practitioners, developing and managing diversity in the workplace to support the dynamic demographics. Timely distributing the study's findings would be vital informing health care organizations' leaders and diversity practitioners on how to engage in DM. I plan to present these findings in DM conferences, workshops, and training seminars to share the findings with other stakeholders and interest groups. I will upload the findings on various academic sites on the internet to be available for researchers and other learners to advance research and practice in the area.

Recommendations for Further Research

I conducted qualitative multiple case studies to investigate the strategies health care organizations' leaders employ to manage a diverse workforce to improve individual and organizational performance. The study's findings are beneficial to (a) health care and

other organizational leaders working with diverse teams or those intending to introduce diversity within their organization, (b) industry leaders that are experiencing challenges with communication with their employees and customers, (c) leaders and employees, including students lacking competency, information and/or the determination to achieve diversity-related organizational goals, and (d) health care organizations' leaders intending to compel employees to perform in every area. Through the experience gained in completing this study, I recommend that future research be conducted using different research methodologies to investigate the different strategies used for DM and their effectiveness in health care organizations. Here longitudinal and cross-sectional studies would be effective in ensuring a larger sample size to provide a more comprehensive and holistic comparison and improve the application of the findings in practice.

In addition, I recommend that future studies explore how DM is implemented in organizational policies and within the organizational culture at different levels of the organizational structure and how the impact inclusion and performance. Also, I recommend that future research explore the socioeconomic impact of using the other diversity groups, organizations, and professionals in organizational development and ensuring sustainable diversity growth. This study's findings could be improved and built upon by addressing any inherent limitations by increasing the scope of the study. Using a larger population and sample would allow in-depth exploration of effective and practical DM strategies across various sectors, which may be later applied in health care organizations.

Reflections

Pursuing my advanced degree has allowed me to acquire invaluable critical and personal and academic skills and experiences. Specifically, I have learned to prioritize, balance, and undertake various roles and responsibilities through completing this project, including family, school, and work. To achieve the goals above, I have learned the importance of time management and developed an attitude of resilience, perseverance, dedication, and determination to complete my studies. The learning process has equipped me with critical and creative thinking and reading skills, synthesis of information, and scholarly writing. I have learned to be patient and remain committed to attaining my goals: completing the program at a personal level. This gave me the realization that regardless of the challenges one may experience if they remain committed, they will achieve their dreams.

I have also learned to be a better listener and observer. I have developed the ability to remain objective despite the temptation to pursue personal biases, such as when collecting and analyzing data, including drawing conclusions based on gathered evidence. Completing this study has also allowed me to learn and understand DM's social and economic benefits, hence the need to support DM in organizations. I realized that despite DM often being underscored as a critical factor in organizational success, the advent of globalization brought the concept and its importance into the limelight. Through the literature review, I learned of the immense task inherent in introducing DM practices into organizations. Finally, the entire doctoral journey has been challenging and demands

engaging in rigorous academic work, commitment, and an immense support system. Regardless, I found the whole journey enlightening, exciting, and thought-provoking.

Conclusion

Globalization has increased the population and number of employees from diverse groups, particularly minorities in the country. One outcome of this demographic shift has been the erection of cultural barriers in the workplace, despite services and provisions of various national and transnational policy to serve as interventions to address the issues (A. Jones et al., 2021; Malik et al., 2018). One important area that has been affected by diversity in health care hence the promotion of equality and respecting diversity in the field, ensuring people place value on each other and can equally access high-quality care. Leaders in health care organizations emphasize the delivery of quality customized care for all populations. The significant disparities remain within these facilities that are a concern to the U.S. medical management system.

The purpose of this qualitative multiple case study research was to answer the primary research question, “What strategies do leaders of health care organizations use to manage culturally diverse workers and therefore increase performance?” The study included eight participants who were sourced from two health care organizations within the State of Iowa who work with diverse populations. I conducted semistructured interviews where I explore the strategies they used to manage a diverse workforce as individuals and/or organizations and based on their experiences.

The interview responses were analyzed, and the findings were complemented through the examination of secondary data. The thematic analysis generated five themes:

(a) leaders used recruitment strategies promoting diversity, (b) leaders encouraged and used communication/feedback, (c) leaders conducted diversity training to encourage diversity, (d) leaders provided suitable working conditions to promote diversity, and (e) leaders encouraged and engaged in teamwork and collaboration. The findings highlighted that those leaders who employed these strategies were successful in their DM efforts and improved individual and organizational performance.

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Appendix A: Interview Protocol

Date_____

Location_____

Interviewer_____

Interviewee_____

Opening introduction

I provided an opening introduction and exchange of pleasantries using the following script: Good morning/afternoon. First, thank you for deciding to participate in this study and attending this interview. My name is Michael Le. I am a doctoral student at Walden University pursuing Doctor of Business Administration (DBA). I am currently conducting a research study entitled "Health Care Leader Strategies for Cultural Diversity in the Workplace."

General Reminders to Participants

1. The interviewer will remind participants of the purpose of the study using the following script: The purpose of this qualitative multi-case study is to explore the Health Care Leader Strategies for Cultural Diversity in the Workplace.
2. The interviewer will reaffirm to the participant that all the information that is shared will be confidential and for the sole use of the study. All the collected data will remain locked inside a storage cabinet in my home office accessible only to me for five years to safeguard the rights of the participants and organization. Upon completion of the five-year storage period, I will dispose of all the paper documentation using a local professional shredding company. I will destroy all

electronic documentation saved on the encrypted storage system using DBAN data wiping software.

3. The interviewer will inform the participant there will be two digital audio-recording devices, one as the primary recording source and the second as a backup will record the conversation.
4. The interviewer will inform the participant that handwritten notes will also be taken during the interview process.
5. The interview will inform the participant that a full transcription of the interview will be conducted and provided to each participant for member checking to ensure the accuracy and resonance of the participant's expressions, views, and statements. The interviewer will schedule a follow-up meeting to review the specific transcription with each participant later.

Participants

The target population and participants included 12 agree (8 participated) health care professionals, managers, and administrators, in the state of Iowa with success managing a culturally and ethnically diverse workforce.

Length of Interviews

All interviews lasted between 30-45 minutes followed by a 20-minutes follow-up meeting on another date.

Central Research Question

What strategies do leaders of health care organizations use to manage culturally diverse workers and therefore increase performance?

Interview Questions

1. What strategies do you use to recruit workers from different ethnic and cultural backgrounds?
2. What strategies do you use to ensure that you obtain multiple perspectives from your employees?
3. What strategies do you use to manage employees who present diverse problem-solving recommendations?
4. What strategies do you use to manage employees with viewpoints based on different social and cultural contexts and fail to understand each other properly?
5. Based upon your experiences, how have your strategies to manage cultural diversity affected your organization's bottom line?
6. What else can you share with me about your organization's strategies for cultural diversity to increase performance?
7. Do you have any additional information you would like to add about the strategies you use to manage culturally diverse workers and increase performance?

Probing questions

Upon completion of the interview questions, the interview will follow up with probing questions if further questioning will allow for additional clarity.

Closing

1. The interviewer will explain to the participants the need to contact them to schedule a follow-up meeting to verify the accuracy of the interview transcript

and engage in member checking to obtain additional information the participants may offer.

The interviewer will thank the participants for their time and contribution to the study using the following script: Thank you for taking time out of your busy schedule to participate in the research study. I will follow up with you in the coming days to schedule the follow-up meeting. Your participation is highly appreciated.

Appendix B: Letter of Cooperation and Confidentiality

Date: TBD

Name of Organization: National Association Medical Staff Services

Name: Lynn Boyd

Address: 2001 K Street NW, 3rd Floor North | Washington, DC 20006

Email: E-mail: info@namss.org

Telephone: Phone: 202-367-1196 | Fax: 202-367-2196 |

Dear Madam,

My name is Michael Le. I am a Doctor of Business Administration (DBA) student at Walden University, conducting a research study called "Health Care Leader Strategies for Cultural Diversity in the Workplace." The purpose of this qualitative multi-case study is to investigate strategies that leaders of health care organizations use to manage workers from diverse ethnic and cultural backgrounds to increase performance.

I identified your organization as a leading body representing health care professionals in the United States and Iowa. I am seeking your assistance to recruit participants who meet all the following eligibility criteria to conduct 30-45 minutes interviews and 20-minutes follow-up meetings:

- living and working in the state of Iowa
- have a minimum of five years of experience in a health management position overseeing a diverse building construction design

- hold a professional medical license or healthcare management professional certification,
- Are currently leading, or have led, a culturally and ethnically diverse workforce in healthcare.

In addition to the interviews, I am requesting permission to review organization documents, such as performance reports, strategic plans, and diversity reports. Confidentiality is of utmost importance to me. I will not disclose any company, leader, or participant in the published study or any subsequent publications using information from this study. The company and participants will be coded to protect their identity. Participation in this research study is voluntary. You may choose not to allow recruiting of participants to take place within your company or provide access to relevant company documents at any time. Your company and its eligible participants may withdraw from the study at any time without any explanation or reason. Any data collected from the withdrawn participant will not be used in the study.

I am kindly requesting you to provide access to a list of participants who meet the eligibility criteria by providing their full name and contact information (i.e., email or telephone number). You will not be asked or be required to provide any supervision during the interviews. Eligible participants will be emailed an invitation to participate in the study along with an informed consent form to review prior to the scheduling of the interview. Providing informed consent will occur by replying to the email invitation with the words, I consent, or by signing the informed consent form prior to the start of the interview.

Because you are the official authority representing your company to grant permission and access to release company documents, I am requesting a release of documents subject to the following conditions:

1. I will use all company documents released to me exclusively for my research and I will not disclose or discuss any of the information with anyone, including friends or family. All documents will be kept confidential.

2. I will not copy, release, sell, loan, alter, or destroy any confidential information released to me, except as authorized by you as the official company representative.

3. I will not discuss confidential information released to me in any environment where other people may overhear the conversation.

4. I understand that it is not acceptable to discuss confidential information even if the company or participant's name is not used.

5. I will not make any unauthorized transmission, inquiries, modifications, or purging of confidential information.

6. I agree that my obligations under this agreement will continue in perpetuity after the completion of this study.

7. I understand that any violation of this agreement may have legal implications.

8. I will only access documents I am officially authorized to access and I will not disclose any trade secrets, proprietary information, or any other protected intellectual property to any unauthorized individuals or entities. If the terms and conditions within this letter of cooperation and confidentiality agreement are acceptable, please print and sign your name, provide your title, and the date your signature below.

Printed name: ____ Michael Le_____

Signature: _____

Title: _____ Executive Director_____

Date: _____

By signing this document, I as the authorized representative for the organization … acknowledge that I have read the agreement and that I agree to comply with all the terms and conditions stated above. I understand that the student will not be naming our organization in the doctoral project report that is published in the ProQuest database or any other subsequent publications. I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies. I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University Institutional Review Board.

Appendix C: Participant Invitation and Consent

Date:

Dear Sir / Madam,

My name is Michael Le. I am a Doctor of Business Administration student at Walden University, conducting a research study called "Health Care Leader Strategies for Cultural Diversity in the Workplace." The purpose of this qualitative multi-case study is to investigate strategies that leaders of health care organizations use to manage workers from diverse ethnic and cultural backgrounds to increase performance.

I am reaching out to you because your organization, hospitals, health care facilities, nursing homes, has recommended you due to your successful experience in managing a culturally and ethnically diverse workforce in healthcare. I am looking for the opportunity to conduct a 30-45-minute interview with a 20-minutes follow-up meeting. The interview will be recorded, and you will have the opportunity to review the interview transcription for accuracy before inclusion in the research study. Please note that participation in the researcher is voluntary and confidential. Your name or any other information that could identify you personally will be excluded from any reports of the research study.

If you are interested in participating in the research, please refer to the attached informed consent form. The form provides detailed information related to the procedure for conducting the study and may assist you with your decision to participate. If you agree to participate, please reply to this email with the words, *I consent*, and I will follow

up with you to schedule an interview date and time that is convenient for you. I am grateful for your valuable time and thank you in advance for your cooperation.

Sincerely,

Michael Le

Doctor of Business Administration Student

Walden University