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Culturally Effective Organizations: Revisiting the Role of Employers in Workforce Development in **Pathways to Careers in Health Care**

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Pathways to Careers in Health Care

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Culturally Effective Organizations

Revisiting the Role of Employers in Workforce Development

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The nation's policy agenda for employment and training increasingly includes efforts to create health career pathways for low-income and skilled individuals—from new entry through advancement—by engaging employers as key partners in workforce development through sector-based partnerships (National Skills Coalition 2018). This chapter presents findings from the Health Care Employer Research Initiative, a four-year partnership between the New Hampshire Office of Minority Health and Refugee Affairs (OMHRA) and the Institute on Assets and Social Policy (IASP) at the Heller School for Social Policy and Management, Brandeis University.[1]

The goal of this research initiative was to examine how New Hampshire health care employers and other key stakeholders might improve the hiring, retention, and advancement opportunities for racial, ethnic, and linguistic minority populations in the state who were new or incumbent health care employees. The project revealed and demonstrated an ongoing need for greater and different collaborations between the workforce development system and health care employers, and a need for building new institutional practices within health care organizations to improve equity in hiring and advancement. We suggest that employer

engagement is critical to developing career pathways that advance health professionals of color. Workforce development programs will move forward with greater success when tied to the related agendas of improving health care performance and reducing area health disparities.

This chapter presents two main areas of findings. First, we categorize key barriers to workforce diversity and inclusion in health care identified through in-depth fieldwork. We find that while New Hampshire had a growing health equity initiative in place, related employment and advancement opportunities in health care were not addressing career advancement for diverse populations, despite an understanding of the benefits of patient-provider concordance. In fact, dominant narratives of meritocracy, resistance to institutional change, and embedded organizational norms excluded low-income workers of color from advancing and achieving family financial security through health care work. The research revealed a consistent narrative that it is up to individuals to become educated and advance, with little insight into how the institutional structures, networks, and organizational cultures of the workplace may influence hiring, retention, and advancement outcomes. These findings provided the partners an opportunity to explore and build conversations and knowledge about new types of institutional practices.

This study went beyond identifying barriers, however, by working with employers and key stakeholders to investigate, think through, and design new approaches to advance workforce development and diversity. Findings demonstrate an ongoing need for greater and different collaborations between the workforce development system and health care employers, as well as new institutional practices within health care organizations to improve equity in workforce development, hiring, and advancement. The research suggests that this career advancement work is likely to move forward with greater success when tied to the related agendas of improving health care performance and reducing area health disparities.

Thus, the second area of findings describes a new framework and theory that emerged to explain the intersection between institutional practices in health care organizations and the advancement of diverse populations in health careers. The framework of "culturally effective organizations" is explained here to inform a new understanding of the problem and to identify levers for change. OMHRA and IASP's framework for culturally effective organizations outlines a new form of coor-

dination and commitment, both within the health care organizations and between employers and external stakeholders (Doupé et al. 2016). Culturally effective organizations are structured to create and sustain a diverse workforce that is representative of the community served. The team's research elaborated and publicized a wide range of benefits to organizations that seek to become culturally effective, including higher quality of care, safety, patient satisfaction, the reduction of regional health disparities, increased revenue or cost savings, and ultimately the economic security, stability, and economic well-being of those who have traditionally been left out of quality health care jobs.

The chapter concludes with a discussion of the ripple effects that continue in New Hampshire today as a result of this work, and it offers considerations for workforce development and/or health equity initiatives interested in partnering to restructure opportunities and policies for systemic and long-term change.

BACKGROUND

The federal investment in the national Health Profession Opportunity Grants (HPOG) program was premised on two important areas of research. First, data indicate that there are good opportunities to educate and train low-income and Temporary Assistance for Needy Families recipients in the health care field for positions that pay well and are expected to either experience labor shortages or be in high demand. HPOG grantees are encouraged to adopt a career pathways framework in structuring and delivering occupational training and other program services. The goal is to "secure positions that have opportunity for advancement and sustainability, ultimately leading these individuals on a pathway to financial self-sufficiency" (Office of Family Assistance 2017).

Second, data indicate that persistent disparities in health outcomes for patients among diverse communities could be reduced by increasing the concordance of health providers and the potential patient community. The Affordable Care Act (ACA) recognized that racial and ethnic minorities are underrepresented in the U.S. health care workforce, which is a problem because, as the Health Resources and Services

Administration found, minority patients tend to receive "better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings" (Cronk and Weiner 2015). Through this research, the partnership had the opportunity to identify pathways that bring low-income populations out of poverty while contributing to a reduction in area health disparities. As the findings presented here suggest, developing strategies to accomplish these broad national goals requires a multidimensional and multistakeholder approach: one that expands beyond the current workforce development rhetoric focused on simply producing a skilled labor force to meet labor market demands.

National data reveal significant underrepresentation among historically disadvantaged workers of color in the health care workforce. Although non-Hispanic blacks make up 12.2 percent of the population, they account for 6.3 percent of active physicians, 5.8 percent of registered nurses (RNs), and 4.2 percent of physician assistants. Hispanics make up 16.3 percent of the population, yet they account for 5.5 percent of physicians, 3.9 percent of RNs, and 4.7 percent of physician assistants. In contrast, non-Hispanic whites and Asians make up 68.4 percent of the population, 86.5 percent of physicians, 83.2 percent of RNs, and 90.8 percent of physician assistants (Cronk and Weiner 2015).

These interrelated points, including underrepresentation, the need for career opportunities that lead to financial self-sufficiency, and the need for greater provider-patient concordance, highlight a growing imperative to develop strategies to improve career advancement opportunities for health care employees of color.

In the context of the changing health care landscape created by the Affordable Care Act, in 2010 OMHRA partnered with a few key champions and organized a statewide effort to raise awareness of health disparities. Together they facilitated the development of the New Hampshire Health and Equity Partnership, a multistakeholder network of organizations and individuals committed to health equity and equity across social determinants of health domains. Guided by recommendations detailed in the *Plan to Address Health Disparities and Promote Health Equity in New Hampshire* (State Plan Advisory Work Group 2011), this group of more than 60 members aimed to diversify the health care workforce to better reflect the populations served and to encour-

age employers to dedicate resources to recruitment, training, and retention of racial, ethnic, and linguistic minorities for staff and leadership positions (State Plan Advisory Work Group 2011). A key strategy to achieve this goal was to apply for and be selected as the recipient of one of 32 Health Profession Opportunity Grants (HPOG) from the Administration for Children and Families. HPOG provides funds to prepare minority and low-income individuals for entry into high-demand health care occupations and offers advancement opportunities for incumbent workers, providing a unique opportunity to advance this work in New Hampshire.

In designing and implementing its HPOG project, OMHRA faced two challenges. First, low-income health professionals of color struggled to secure full-time, quality jobs and/or achieve career advancement. Second, health care employers were unconvinced that workforce diversity should be a priority in New Hampshire, a predominately rural and white but rapidly diversifying state. The HPOG project, the New Hampshire Health Profession Opportunity Project (HPOP), supported 1,051 low-income individuals to pursue health occupation training, of which 845 completed training in health careers, and 782 attained employment, with 692 employed in health care. In addition, HPOP expressed an intentional focus on workforce diversity in its proposal and successfully engaged 28 percent of participants from racial, ethnic, and language minority populations, exceeding the target of 25 percent (Office of Minority Health and Refugee Affairs 2016).

These job placement and advancement objectives were achieved through a multilevel workforce development model. In addition to working with individuals and families by providing case management and support services and facilitating training, OMHRA dedicated additional HPOP funds to capacity-building initiatives with key workforce partners, employer-based training initiatives, and regional business advisory councils. Still, the primary focus was on job training and matching the labor supply with positions in demand.

IASP partnered with OMHRA to examine specific questions related to what, if anything, was required beyond human capital investments in individuals and job matching, to ensure the hiring, retention, and advancement of those enrolled in education and training. IASP's research was designed to investigate the links between participant-level barriers and systemic, sectorwide barriers to successful workforce

development and advancement in health care for racial, ethnic, and linguistic minorities.

Diversity and Disparities in New Hampshire

In 2010, when this project started, many politicians, business leaders, and residents believed that issues related to diversity did not apply in New Hampshire. However, demographic trends illustrated that this was not the case. The state's minority population grew from 4.7 percent in 2000 to 7.7 percent in 2010 and accounted for 50 percent of the state's population growth from 2000 to 2010 (Johnson 2012). Moreover, diversity in New Hampshire is spatially concentrated; in metropolitan areas in the southern part of the state, people of color represent a significant percent of the population: 18 percent in Manchester and 21 percent in Nashua in 2010, about 20 miles south. Furthermore, diversity was increasing across every age demographic, but especially among its youngest residents. New Hampshire's Latinx youth population grew 52.7 percent from 2000 to 2008, fourth in the nation for greatest percentage change (Moeller 2010).

Over 20 years of refugee resettlement also contributed to New Hampshire's changing demographics, including the arrival of Vietnamese, Bosnians, Mesketian Turks, Liberians, Iraqis, Bhutanese, and others. Refugee families are primarily resettled in the cities of Nashua, Manchester, Concord, and Laconia. Adult refugees bring a wide range of professional and educational backgrounds, and many are highly motivated to further their education. The HPOP program covered each of these newcomer communities in addition to Native-born people of color.

New Hampshire's poorest residents are disproportionately racial and ethnic minorities. In the years leading up to HPOP, nearly one-quarter (24.4 percent) of the state's African American population lived below the federal poverty line, as did 16.6 percent of the Latinx population, and 18.2 percent of the Native American population. Additionally, 19.7 percent of all other diverse populations were considered poor, compared with only 7.4 percent of New Hampshire's white residents. Rising wealth and income inequality, changes in the structures of work that have increased inequality within and between firms, and the rise of temporary work and contingent employment all contribute to these inequities (Blank 2009; Kalleberg 2013; McKernan et al. 2017).

At the time this study was conducted, the state was still reeling from the effects of the recession. In New Hampshire, the unemployment rate for racial minorities from 2007 to 2011 was 9.1 percent and for Hispanics/Latinos was 12.6 percent. For whites, it was 6.1 percent (6.3 percent for the state as a whole). These trends were reflective of national economic and sector-specific inequalities. One in five adults working in full-time jobs earned an hourly wage that placed them below the federal poverty line for a family of four, and people of color composed 47 percent of this population of working poor, despite being only 30 percent of the total U.S. labor force (Osterman and Shulman 2011). The recession also slowed staff turnover of older, more experienced health care workers who postponed retirement. This limited opportunities for new positions to be filled by younger workers and delayed employer interest in the upskilling of incumbent workers.[2]

Career advancement over the life course and larger social mobility patterns are typically explained as the result of a combination of factors, including an individual's level of education and skill and whether the labor market in any particular region and sector has a demand for individuals with those skills (Holzer 2004; MDRC 2013; National Conference of State Legislatures 2015). Our study expands this individualistic perspective by explaining the institutional and relational factors, as well as social patterns of privilege, tied to race and class that affect workforce development and diversity efforts. To ground this broader perspective in local evidence, we gathered data describing actual workforce demographic and advancement barriers faced by diverse low-wage health care professionals in New Hampshire and explored strategies to overcome them.

RESEARCH DESIGN AND METHODOLOGY

The partnership goals and research strategies were shaped by a shared definition of the problem. Long-term success, which includes the economic self-sufficiency of participants of color, requires the participation of health care employers in three new ways: 1) to develop more effective employer commitments to this goal through new policies and practices, 2) to be partners in the development of skill and

placement components of workforce training, and 3) to be more fully engaged in long-term partnerships with the communities they serve.

Data were collected through in-depth qualitative interviews, literature reviews, local data analysis, and the engagement of employers and other stakeholders in the development of findings. IASP and OMHRA's collaborative study was designed around the following three central questions:

1) How can New Hampshire health care employers create a more diverse workforce and foster greater recruitment, retention, and advancement for racial, ethnic, and linguistic minorities in the state?
2) How can the workforce development field better prepare and support both workers and employers in the health care sector to improve minority hiring, retention, and advancement along career pathways in the state?
3) What opportunity structures or bridges need to be developed or leveraged to build and sustain a more diverse and upwardly mobile minority health care workforce in New Hampshire?

In this research, the use of the term *diversity* is limited to racial, ethnic, and linguistic diversity. Data collection and ongoing engagement were structured around three core areas:

1) **Regionally based research.** IASP surveyed and interviewed over 100 New Hampshire health care employers, industry association leaders, job developers, incumbent health care workers across a range of positions, and community leaders to document challenges, strategies, and best practices for developing a diverse health care workforce and related career mobility pipeline. We included hospitals, long-term care facilities, home health care agencies, community health centers, mental health centers, and dental care service providers from across HPOP's four geographic areas. All the research took place in southern New Hampshire, which was the operational target area for the HPOG grant. All interviews were recorded, transcribed, and coded for relevant themes.
2) **Employer engagement and feedback.** IASP engaged directly with employers throughout the study. In addition to conducting

employer interviews, IASP presented materials and engaged industry employers at two statewide annual meetings: the home health care association and the long-term care association. At these meetings, employers actively engaged in discussion about the issues. OMHRA organized regional Business Advisory Council meetings several times each year, and IASP presented and engaged participant employers around its ongoing work regularly, building employer knowledge and learning from these interactions. Finally, the partnership created a research advisory group that included two employer representatives who provided feedback and insights as the project developed. The research team vetted findings from interviews with employers and industry leaders throughout the project to document reactions, key questions, and areas of incongruence between the literature and the local context.

3) **Engagement with the workforce development community.** IASP built on OMHRA's existing partnerships with the community college system, the statewide apprenticeship program, the Temporary Assistance for Needy Families program, and state and local workforce development directors. The research team engaged these six experts in vetting initial findings and identifying actionable steps to align workforce diversity efforts with existing programs and the needs of employers.

Throughout the project, IASP reviewed and synthesized literature, triangulating key findings related to workforce diversity and inclusion in New Hampshire with findings from the wider field. This helped ground our work in the health sector and was instrumental in making a case for culturally effective organizations, as described below.

OMHRA and IASP also formed an advisory committee comprising leaders from local foundations, employer associations, employers, state government, and the community college system. These partners provided feedback on draft reports, helped align findings with local policy priorities, and were instrumental in identifying additional resources that allowed IASP researchers to expand on key findings from the Employer Research Initiative (ERI), as the project came to be referred to over time. Two subsequent studies funded by the New Hampshire Endowment for Health extended elements of this project: *Beyond Supply and*

Demand, which focused on the role of networks in career advancement and racial equity, and a case study of a community health center that was actively working to become a more culturally effective health care organization (Santos 2015; Santos et al. 2016).

The overall goal of this study was to inform, improve HPOP, and support longer-term statewide efforts for workforce diversity in health professions. The four-year initiative produced a range of reports, briefs, research, and a case study, all designed to actively engage health care employers and industry associations, the workforce development system and its providers, and the wider community of stakeholders interested in issues of health disparities, health access, and employment equity (Boguslaw et al. 2016). Indeed, this work helped energize and coalesce interested stakeholders in the state, expanding, solidifying, and continuing the work as this is written, more than two years after the formal end of the project.

THE UNIVERSITY PARTNERSHIP PROCESS

This partnership process and model of engagement provided opportunities for employers, educators, workforce development leaders, and community organizations to share their experiences with workforce diversity and to learn from experts in the field of workforce diversity. This work occurred through the quarterly Business Advisory Council meetings, which were facilitated by IASP and HPOP staff; HPOP leadership meetings that included representatives from state agencies; and through participation in the New Hampshire Health and Equity Partnership Workforce Diversity Work Group, which brought together interested partners and stakeholders. IASP also had the opportunity to present to two statewide industry association member meetings in home health care and long-term care.

One of the unique aspects of this partnership was that a staff member from OMHRA, who had several years of experience with the agency, was able to become a half-time staff member with the Brandeis team while continuing to work half-time at OMHRA (with a different scope of responsibilities). This individual provided a bridge between the two organizations and was able to offer important context and access to

New Hampshire–based resources. Her work with IASP was separate from her position at OMHRA, so the actual partnership process was between IASP and other OMHRA staff, as well as its director. Additionally, OMHRA's director had a history of working with universities in community-academic research partnerships, and had knowledge about what a participatory community partnership required, including a process for making a partnership participatory, equitable, mutually respectful, and engaged. These factors facilitated a close partnership designed to engage and unite the unique perspectives of both researchers and practitioners. It enabled IASP to achieve a high level of embeddedness in the New Hampshire workforce and health equity communities, producing higher quality and more relevant findings.

OMHRA contracted with Lutheran Social Services (now Ascentria Care Alliance) to implement the case management and training portion of the HPOP, with OMHRA playing a very engaged supervisory role and serving to introduce innovative elements to the program design and delivery. IASP's partnership was with OMHRA, and thus IASP participated in program review meetings, but its work was implemented in partnership primarily with OMHRA and not the direct service provider. This partnership structure appropriately kept the research focus on the broader contextual and systemic factors that affect the success of health professionals of color, and it helped separate IASP's role from a more traditional evaluation partner focused on participant outcomes. University-conducted research brings a sense of validation and reliability about the findings. Being from "out of state" meant that IASP was not perceived as one of the state's stakeholders who might have conflicts due to confidentiality, prioritization of findings, or self-interest.

FINDINGS

New Hampshire Workforce Demographics: Missing or Missing Out?

We began by investigating where people of color were working in health care in the regions of HPOP focus in New Hampshire. In 2004, a landmark national report, *Missing Persons: Minorities in the Health Professions* (Sullivan 2004), drew attention to the fact that African

Americans, Hispanics, American Indians, and certain segments of the Asian/Pacific Islander population were missing from the U.S. health care workforce. We investigated this notion in New Hampshire and discovered that these populations were in fact not missing from the health care workforce. Instead, they were overrepresented in the lowest wage positions and in workplace settings with few opportunities for advancement.

In 2008, the aggregate Equal Employment Opportunity Commission report for New Hampshire hospitals reported 29,251 total employees, with only 1,167 minority workers (4.0 percent). Ambulatory care was even less representative of the population, with 7,276 employees statewide and only 231 minorities (3.1 percent). Two of Manchester's largest hospitals employed a workforce that significantly underrepresents the city's increasingly diverse population: 6.2 percent (119 minorities out of 1,895 total employees) at one hospital and 2.6 percent (88 minorities out of 3,381) at the other.[3]

While overall representation in the workforce illustrates part of the picture, a closer look at the distribution of workers in more granular occupational categories by race and ethnicity reveals significant opportunity gaps. In 2008, there were 7 minority executive/senior level officials or managers in New Hampshire's entire hospital system and 23 minority first/mid-level officials and managers. The majority of diverse hospital workers were concentrated in low-level professional, technician, office/clerical, and service worker positions, indicating that New Hampshire's minority health care workers were missing from the more coveted higher quality jobs.

In addition to sector-based and occupational segregation, IASP's research demonstrated that the type of employer (and the quality of work offered through that workplace) contributes to inequities in career entry and advancement opportunities. For example, LNAs (licensed nursing assistants) in nursing homes and residential care settings report a different work experience and compensation package than LNAs in hospitals, despite holding the same occupational title. Hospitals provide higher wages, more stability, and better benefits, and they are most likely to have opportunities for advancement when compared to community health centers, long-term care facilities, and in-home care providers. For many health professionals, hospitals represent the ultimate workplace for good jobs—those with full-time work, benefits, and

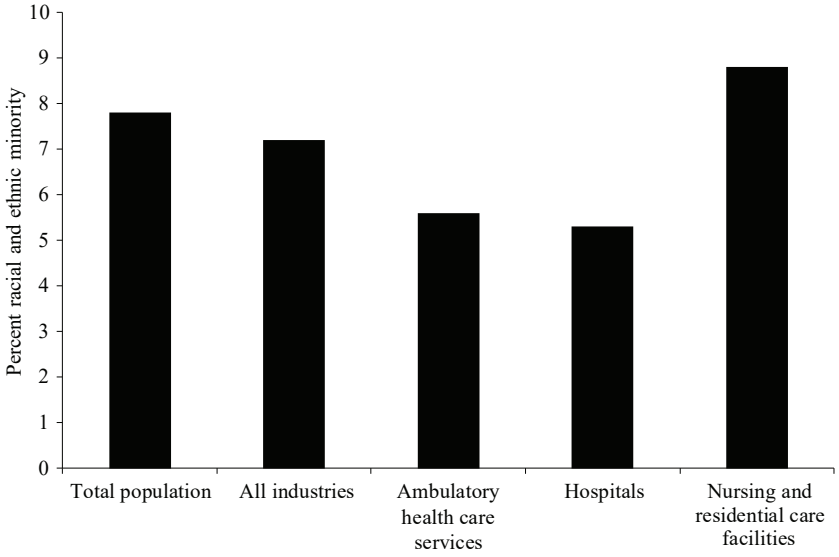
opportunities for advancement. Figures 6.1 and 6.2 show that across the state, as well as in the primary HPOP service area of Hillsborough County, health professionals of color are overrepresented in the nursing and residential care workforce (13 percent) and underrepresented in the hospital workforce (6.5 percent) compared to their participation in the labor force (9.5 percent) (Santos 2014). Average monthly wages in 2012 in ambulatory care were $5,288, in hospitals $4,395, and in nursing/residential care $2,436. These wage data indicate how the type of workplace, in addition to the type of occupation, affects the economic security and well-being of the workforce.

These data demonstrate the presence of racial and ethnic inequalities between and within occupations and workplaces in New Hampshire (Boguslaw et al. 2013, 2015, 2016; Doupé et al. 2016; Santos 2014; Santos and Boguslaw 2015; Santos, Boguslaw, and Venner 2014). Through conversations with employers and workforce development leaders, IASP and OMHRA realized that this more detailed approach to understanding workforce "diversity" challenged current assumptions. Contrary to the national narratives focused on the idea that minorities were "missing persons" in the health care workforce, this study found that health professionals of color were not missing in the sector as a whole. Rather, they were "missing out" on opportunities to advance out of low-wage positions and jobs at workplaces with fewer benefits into higher-quality, higher-level jobs. Employers in New Hampshire, especially long-term care and in-home health care providers that employed a large percentage of low-wage workers of color, were responsive to these findings. As a result, this project was able to shift the conversation away from a focus on recruitment and hiring and toward a more accurate, needed focus on retention and advancement.

Barriers to Opportunity

Entry-level workers seeking jobs and advancement in health care face barriers from multiple sources, including an individual's insufficient education and training for specific positions, knowledge about opportunities, experience, and different levels of interest in particular forms of health care work (Holzer 2015). Our research corroborates existing work that suggests that in addition to individual barriers, health

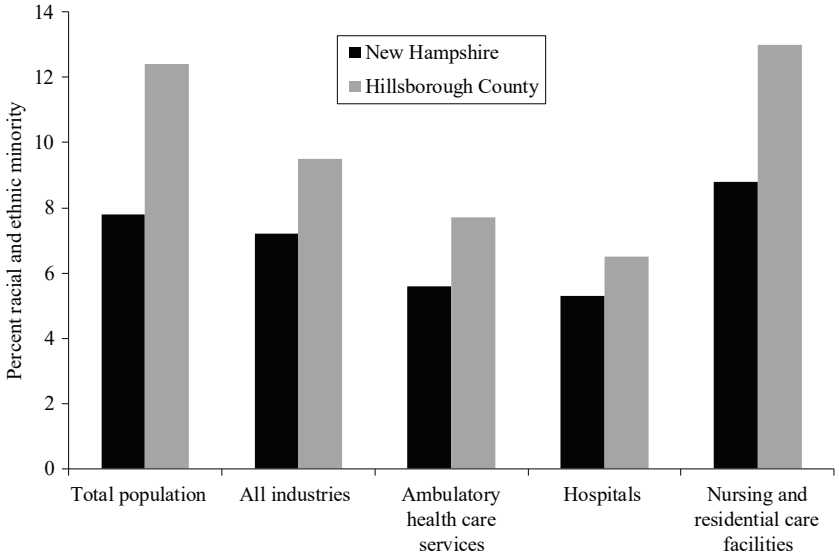
Figure 6.1 Minority Health Care Workforce, New Hampshire



SOURCE: Santos (2014).

care workers of color seeking to advance face a range of structural barriers that are institutional, relational, and organizational in nature. These fall into three key areas. The first is discrimination embedded in institutional structures. Here we found an absence of formal organizational commitment to and understanding of the value of workforce diversity across professional positions, variations in leadership to address issues, and, as a result, unequal opportunity. The second area of findings revealed the way that informal labor networks function to restrict access to new opportunities for entry and advancement for health care professionals of color, limiting inclusion and equity. The third is how employers understand and make decisions that impact diversity in the context of their perceived bottom line. Together, these structural issues contribute to a new way of thinking about policies and practices that improve the entry, retention, and advancement of diverse populations in health care positions.

Figure 6.2 Minority Health Care Workforce, New Hampshire and Hillsborough County



SOURCE: Santos (2014).

Finding 1: Institutional Structures and Embedded Discrimination

New Hampshire health care employers and employees hold a wide range of opinions about the advancement challenges faced by diverse populations in health care. These perspectives reflect a sector and population in transition. Some employers manage their changing patient and workforce population with intention, while others produce negative impacts due to lack of attention to, or understanding of, structural barriers to job entry, retention, inclusion, and advancement. Overall, our research revealed at that time an unwelcoming climate in professional health care institutions for people of color in New Hampshire, with some exceptions. Positive examples of change came from key employers leading intentional efforts to embrace, manage, and promote diversity and equity within their own organizations.

Several employers aware of the demographic changes under way led their health care organizations to embrace concentrated efforts to

diversify their workforce and through this diversity provide quality care to the community or region. One health care employer explained:

> *We changed [our practices around hiring? Recruiting?] purposefully because . . . you're part of the community so you want . . . to look like what the community looks like. So, it was actually taken on as a strategic initiative of the board of directors and the executive leadership . . .*

In this instance, the organization's patient population was more diverse than other area health care providers', thus they were more sensitized to the issues of patient-provider concordance to meet the goals of outreach and adherence to treatment and follow-up procedures.

On the other hand, respondents recognized that not all employers were sufficiently prepared to recruit and manage a diverse workforce, and that with demographic change, stereotypes and discrimination also become a key factor in hiring and advancement. Discrimination, avoidance hiring, and a wide variation in management approaches all contribute to unequal outcomes in career advancement. Examples include situations in which the scheduling manager gives less desirable shifts to people of color, the hiring manager will not hire people of color, or the director says that the organization needs to prioritize the comfort of their patients. From these examples we understand they are referring to implicit bias and that both staffs and patients act in ways that reflect their discomfort with difference. The source of these problems stems from decision making and discretion at different levels within the organization, but solutions need to be comprehensive in order to rise above implicit bias and discomfort. Some examples below illustrate this point.

Employer perceptions were frequently raised and discussed at length, with one health care employer reflecting,

> *Everybody has opinions. People who are here, just because their culture is different, they think they're illegal or something.*

Another explained,

> *I think that there's enough New Hampshire employers that have insufficient experience at managing a diverse workforce that they may imagine the worst. You may have to address fears that people have about, oh, they're [i.e., people of color] all lazy, or, oh, none of them know how to tell time and they're not going to show up on time. Or, "I can't have them all sittin' in the lunch room speaking*

Spanish and leaving everybody else out." Or, whatever unfortunate negative stereotypes people may bring to the table as well.

Employees also reported the concern that despite their qualifications they may face discrimination in hiring. One health care employee of color said,

Sometimes I wonder . . . [there are] times where I put my name on something . . . like an online application, and then should I lie? Do I put "Chavez" on there—then I'm not going to get a call back? And I think about that a lot, which is awful . . .

While another health care employee of color was told by friends to apply only online:

If they see you, they won't hire you.

At the same time, some people in the field consider diverse language and cultural backgrounds to be an asset. One HPOP job developer said,

I told them to put on their résumé that they speak more than one language. Employers have said, "I am hiring you because you speak Spanish."

These findings indicate that there are many mixed messages in New Hampshire about how diversity is or is not valued in the health care workforce, and that the degree to which health professionals of color feel welcome depends largely on the leadership and organizational culture of each workplace.

Health care employees, both white and nonwhite, described a pattern of observed or experienced discrimination. One white health care supervisor described the environment for diverse populations:

We used to hear it from the hospital all the time, "She doesn't like me because I'm Spanish, she doesn't like me because I'm Islamic." It was terrible . . . I had a Jewish employee that was asking for High Holy days off and the other supervisor was having a fit. I was like, "For God's sake, she's going to work Christmas and Thanksgiving, what do you care? Just switch it!"

Another health care employee of color reflected on the example of a supervisor, also a person of color, who had left the job:

I don't know if this is the reason she left, but the next boss is not black, isn't minority. It's just really different. She is treated differently [i.e., better] by our highest boss. And I'm not the only one who is seeing it—they are not minority, but they are witnessing it.

Managers who arrange schedules for health professionals have significant influence on schedules, hours worked, and opportunities for advancement. One health care employee of color describes here how her ability to work was restricted by a manager's discretion.

> *My schedule was, like, stable. I had clients. . . . I was there eight months. . . . I was used to working overnights with them and I said I don't want to work overnight shifts. Can you guys give me morning hours? . . . When the month got there they sent me the overnight schedule. . . . Then I called them, I'm like, didn't you see my letter . . . ? They took away all my hours and I didn't have any hours for a month. When I went in there, they had hours, but she didn't give it to me. I know, I was sitting right next to her and I could see the hours she had available, but she was just like . . . she wouldn't give them. I'm like, "Wow."*

This individual continued to explain that she was sure it was discrimination, that night shifts were perceived as okay for a person of color, and that neither the schedulers nor the clients would schedule a person of color for daytime work.

When asked about the work environment in health care for employees with diverse backgrounds, one white health care employee said,

> *Yeah, I think it's harder for them. . . . In New Hampshire, there is still, in my opinion, this underlying expectation of, you know, this population is lazy, and this population doesn't show up. That population, no they're not going to last.*

These perceptions and experiences stem from institutional structures that enable staff to assert unequal workplace benefits and work conditions, which have a direct impact on the financial instability of families of color. What emerged from interviews with many employers was that leadership in this area is critical, but even with strong leadership, equity efforts may not necessarily be supported at all levels of the organization. For example, in long-term care, one director shared how patients (typically elderly white residents) were often uncomfortable with providers who speak a primary language other than English and have accents. This puts the employer in a position where they must navigate a delicate balance between pleasing their paying customers while also defending their choice to hire a skilled employee. Although not yet the norm, another director describes how to explicitly encourage patients to remain open to a range of providers:

> *And I'll say to a patient, "Today you're having difficulty because this is new. Once you've heard this person speak for a while, you'll begin to become accustomed to the rhythm of the language, you will, and you'll love her or you'll love him," and they do . . .*

In cases like these, organizational leaders must be acutely aware of the different manifestations of discrimination in their workplace and intervene. In other cases, interpersonal dynamics in the workplace may lead to ambiguity. Another employer provided an example of not being sure if discrimination was taking place with the following account:

> *One of our nursing assistants . . . was a preceptor to two women, both from African countries. So, some accent, the color differences, and she felt that when she told them what to do, they should do it. They felt, well, we've had education, we've had experiences in other environments, let's be collaborative. You know, you say we should do it this way can we talk about . . . we've done it this way in other places, maybe, you know, why is it different here? And her feeling was, no, I tell you what to do, and you do it. And we didn't know whether or not that had a racial bias or a cultural bias. What we said is that, "this is not the way we converse with people. You're a preceptor, here is your role, there's human dignity involved here," so we want to be open to the conversation.*

In discussions with employers about how to improve the hiring, retention, and advancement of diverse populations in the health care setting, it was clear that an intentional process needs to be put in place by leadership, and that some misconceptions about the value or importance of diversity for the health care setting could be addressed more directly.

Related to the first issue, intentionality and leadership, one health care employer suggested one challenge for the field is that

> *there has to be kind of a way to talk about what people bring in addition to their language skills that may be beneficial for your organization, because there is a lot.*

And, a white health care employee reflected,

> *Hispanic culture keeps their elderly with them at home. It has a huge impact on the whole family. So they may need to go home at lunch to look after them . . . if we're going to embrace their language and culture to help us deal with these people coming through, then we have to deal with that, have to accept it. We can't*

> *just say, we want your language and your cultural knowledge, but forget your real life.*

And another white health care employee suggested,

> *I think maybe they could have some sort of guidelines. People in a hospital, you might tend to pick someone who's white. . . . I think they might not accept as many other applications because they're, you know, the ratio of people who are white to people who are not white is very high. . . . Cause, they might not be doing it consciously. They might just be, in the back of their mind, and they're not even realizing who they're picking, I guess . . .*

Indicated through these and other interviews, the research team concluded that without institutional attention to the issues of diversity, its contribution is not valued, thus it is not introduced as part of job descriptions in hiring or as qualities or skills that might drive retention and advancement in addition to skills and other more traditional criteria.

The research team also found that employer and workforce leaders lacked an understanding of how diversity and equity affect community economic stability and mobility, institutional performance, quality of care, and the reduction of health disparities. The project team met with a group of employers to discuss initial findings and next steps after the completion of sector interviews to gauge leadership responses. One of the strong messages that came out of this meeting and several others that followed was health care employer beliefs that the absence of diverse populations across job categories had no negative effect on their bottom line or on population-level health disparities. Further, without evidence of these ties, employers believed that hiring based strictly on skill, education, and experience constituted a functional opportunity structure and should continue, perpetuating a diversity-blind approach to workforce development and advancement. Issues of diversity in the workplace were confined to a discussion of cultural competency training, which was covered as part of human resources orientation or training for new employees and was believed to be sufficient.

Finding 2: The Role of Informal Networks in Career Advancement

> *I've seen the staff treated by patients, certainly . . . you know, racist terms and things said, but no, I think [our organization is] very open and very diverse, and the hiring process is very fair.*

This study found that in addition to the explicit forms of discrimination described above, the structure of informal internal labor markets perpetuates a more subtle form of network-based racial inequality at work. Some individuals and groups of people enter the labor market with strong networks that can link them to opportunity, while others must work to intentionally establish, build, and maintain these networks to produce the same level of opportunity. While the role of social capital and personal networks in job attainment is well documented, how it exacerbates the exclusion of diverse populations' career advancement is understudied (Granovetter 1977; Lin 2000). The white respondent below recognized the privilege that her networks provided at different stages of her career path.

> *My first position at the [location] would normally have never have happened for a new grad except for that I knew someone . . . my supervisor there at the time when I got hired . . . and the school nursing jobs that I took, again would have never been given to a new grad, but I knew the school nursing supervisor.*

Network advantages are not only reserved for white health professionals. Several respondents of color expressed pride in the fact that their high-quality work was recognized by their employer and that they were encouraged to make referrals from within their ethnic community.

> *No, I think they prefer us because I think they found when they will hire one or two people at first . . . then they look for [more from the same ethnic background]. . . . [From ___'s] husband's experience they were happy to hire me and . . . my other sister.*

It is widely recognized that networks are the most common way to get a job (Hensvik and Skans 2016). However, what is less understood is how these processes become institutionalized and racialized, affecting career advancement and career paths (Bayer, Ross, and Topa 2008). Employers frequently use their existing employees' networks to recruit new hires or to take recommendations for employees who should advance, with the argument that increased networks create a larger pool from which to choose the most skilled candidate. Thus, the workforce recognizes the role of networks while also reinforcing the idea that occupational status reflects both skill and merit. However, networks do more than broaden the pool from which employers hire. The following quotes illustrate how networks help people advance in their

careers—for example, by guaranteeing that the candidate is considered based on who she knows, and by gaining access to a competitive high-quality hospital job with benefits.

> *My mother worked at ___ Hospital... so she said "Well if you don't want to work there anymore, why don't you try working at ___? I love working [there]." And I went, "Okay, who do I call?" And she gave me a number and I called up and I said "My mom said I should call you." And she said "Who's your mom?" and I said "[name]" and she said "Oh well come on down." I went down and it was almost like a formality. Here, fill out these papers.*

> *I used to play [___ sport], and last year my friend, I told her I wanted to get back into health care because I wanted to go to school and she told me that they were hiring at [name of Hospital]. It's really about who you know and I got really lucky. . . . It's really hard to get into a hospital, especially a hospital like that with so many great benefits. I got really lucky.*

Are these employees "lucky," or are they tapping into broader social stratification patterns to get ahead? How do these patterns relate to workforce diversity and equity? In New Hampshire, as we have demonstrated, hiring managers and others in positions of power are predominantly white. Our research with incumbent health professionals revealed that networks in the health care sector in southern New Hampshire are relatively small and insular, and health professionals in New Hampshire stay connected to the same people (their teachers, supervisors, coworkers) over time, even when changing jobs. This means that relationships and reputations hold valuable currency that influences career advancement decision making as noted in the literature (Alvó-Armengol and Jackson 2004; Cappellari and Tatsiramos 2015). As the following quote from a nursing professor demonstrates, these close relationships mean that to recommend someone, managers or professors don't even need to pick up the phone to call someone—they can just make referrals or recommendations throughout the course of their daily life.

> *Or the fact they [nurse friends] work there [at an employer where the student wants to work] and they say to them "I just told so and so to come over and apply. You're going to love her." It's not even like we're calling. We're talking to the people and you're seeing them all the time.*

These close-knit networks can be either beneficial or exclusionary, depending on relationships and power dynamics in school, work, and communities. While some supervisors and organizations encourage career advancement, others do not. The following quote illustrates how one health professional felt blocked from advancing in her job because of a lack of encouragement and support from her supervisor.

> *So, I reported to this person . . . [she] was not supportive in [my] continuing after she went to get her master's and was supported [by the same organization]. She wouldn't . . . didn't want me to succeed. It was challenging.*

Employment and training programs can also foster a welcoming or exclusionary environment. One student of color explained how she felt excluded in her LNA program because of the lack of instructors of color, as well as the "resistance" she believed her classmates and teachers expressed to diversity. This experience affected her ability to develop positive networks during her training program and also affected her academic performance and aspirations for what she believed she could achieve in her career.

> *The people [at school] there were definitely welcoming, but I kind of felt excluded. Even if I sat on the front row I still kind of felt excluded. I wish that there was a diverse crowd. I didn't really talk to anybody in my class. I'm a very welcoming person, but I just feel like people are very resistant towards diversity. . . . I definitely felt excluded and I know if I was in a more diverse crowd, I would have done better in LNA school. Not just recruiting, but even the teachers . . . it kind of would have given me more hope like, "Oh, if they did it then I can do it too." That is the only thing that I would probably change about my whole education experience.*

A more extreme theme of network-based exclusion came from a set of white health professionals who expressed concern about the growing diversity in New Hampshire, perceived affirmative action, and the implications of these trends on job competition. The following health professional expressed her feeling that

> *we need to help our own people,*

meaning that she would be much more likely to extend or share opportunities with other white health professionals over people of color.

> *I've heard they have an advantage because they have to hire so many [people of color] and that's okay, but I feel that we need to help our own people and I think we're at a point where we're just helping so many that we're in a mess. I mean, we really are.*

These findings show that health professionals in southern New Hampshire leverage resources through informal networks that we often believe are provided through internal labor markets and formal institutional procedures. In addition, relational factors operate differently for people of color compared to whites due to exclusionary environments and the hoarding of opportunities by people in power. If networks played no role in career advancement, we would have a more meritocratic system in which the level of education, human capital, and value to the broad mission of the organization of each individual might contribute in a larger way to their career success. Instead, we observe a system in which individuals are embedded in networks, and those networks are embedded in a society that produces racial inequality because of institutional and systemic structures.

Finding 3: Diversity and the Bottom Line

The majority of New Hampshire employers, at the level of director or unit manager, expressed significant skepticism about the importance or need for hiring a diverse workforce in order to improve community wealth, patient outcomes, or business performance. Two issues were raised.

First, there was general agreement that it was not the business of the health care organization to address wealth inequalities in the community that might be ameliorated through greater attention and prioritization of hiring and intentional advancement. Meritocracy and an assumption of individual responsibility was the normative frame. The most common managerial response when faced with discussions about the value of recruiting and retaining an increasingly diverse workforce was to state that they provide staff cultural competence training. In doing so, employers revealed what we theorize to be either a lack of understanding that workforce diversity is about bringing in new diverse workers, and has little to do with staff training on issues related to culture, or a reflexive resistance to engaging with a new topic that touches upon issues of race (Emerson 2017; Kowal, Franklin, and Paradies 2013).

Individual and organization-level cultural competence is widely accepted as an essential component of health care delivery. The National Quality Forum (2012) defines cultural competency as the "ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable." Culturally competent care is shown to improve patient satisfaction and service utilization patterns, and increase adherence to treatment plans, particularly when health care professionals and patients share similar backgrounds—known as "patient-provider concordance" by race, ethnicity, and language (Cooper and Powe 2004), a dimension of workforce diversity. However, cultural competency training, in the provider organizations reached through this research, was not broadly embedded throughout institutions. In cases where training is offered, it typically occurs as part of the initial orientation process. A few organizations reported offering an annual or biannual refresher. Employers who provide any training at all strongly believe it to be sufficient (Powell 2016; Villarruel 2004).

Second, while cultural competency has been espoused as a strategy to enhance customer satisfaction, facilitate internal communication within the workforce, and improve organizational performance, employers did not understand the connection between a diverse workforce and their bottom line performance (Weech-Maldonado et al. 2012). Thus, we were asked on numerous occasions to "prove it," or no investments or shifts of practice would be made.

In summary, the research findings indicate that health care employers are largely unaware of the benefits of a diverse workforce for building community wealth, improving business performance, and reducing health disparities. Bias or discrimination occurs through the absence of formal institutional practices to improve opportunities for hiring diverse workers, and through informal networks that restrict opportunity structures for entry and advancement. The findings suggest that there are important roles for both employers and key stakeholders to play in moving the opportunity structure to function in a more inclusive and equitable fashion, with important benefits for the community and the health care system.

A FRAMEWORK FOR OPPORTUNITY: CULTURALLY EFFECTIVE HEALTH CARE ORGANIZATIONS

These research findings led the partnership and its advisors to dedicate significant time to creating a framework that would address, in a comprehensive way, many of the challenges to employment inclusion and advancement among southern New Hampshire's diverse populations.

The research team conducted a systematic review of standards, best practices, and recommendations from national standard-setting organizations seeking to improve quality of care and reduce health disparities via organizational cultural competence. While as a project we maintained our primary focus on the hiring, retention, and advancement of diverse populations in health care positions, it appeared that in order to raise awareness of diversity as a priority, health care employers had to become engaged through a range of strategies. This led to the development of a new framework for "culturally effective organizations" that illustrates the intersections of workforce development, diversity, and inclusion in the workplace; organizational performance; and the reduction of health disparities. In this section we discuss this model and how each component of the framework advances health care job opportunities, institutional health care performance, and community health equity.

Culturally effective organizations enable, cultivate, and support the delivery of high-quality health care for all groups of people. The result is improved quality of care, enhanced patient safety and satisfaction, better health outcomes, a stable and skilled workforce with higher employee retention rates, administrative and management improvements, reduced health disparities, lower risk of liability, and fiscally sound health care organizations. Seven fundamental elements form a framework to guide the development of culturally effective organizations. The elements (see Figure 6.3) include leadership, institutional policies and procedures, data collection and analysis, community engagement, language and communication access, staff cultural competence, and workforce diversity and inclusion. Creating a culturally effective organization requires attention to all aspects of diversity. Although racial, ethnic, and linguistic diversity was the focus of this project, this framework

Figure 6.3 Framework for a Culturally Effective Organization

SOURCE: Gaiser et al. (2015).

led to active discussions about diversity of age, gender and sexuality, physical and mental disabilities, religion, and more. "Inclusion puts the concept and practice of diversity into action by creating an environment of involvement, respect, and connection" (Jordan 2011).

Culturally effective organizations are actively shaped and reshaped through the implementation of each of these seven elements. Reshaping occurs as organizations periodically evaluate progress toward organizational goals, while providing regular staff and management training, education, mentorship, and coaching. Each of the elements outlined below is followed by examples of potential action steps in which health care organizations and their leadership can engage to achieve cultural effectiveness.

1) **Leadership.** Executive leadership and boards of directors formally model the organization's commitment by including consideration of cultural effectiveness in the strategic planning process and overall organizational expectations and practices. Leadership is responsible for guiding the organization to address biases and overcome resistance to change, as well as each of the following tasks:
   - Establish concrete goals, objectives, and strategies to meet cultural competency- and diversity-related targets with both executive and midlevel management.

- Gather results of formal assessments of organizational performance toward reaching these goals and report them to the board of directors on an ongoing basis.
- Use assessment findings to inform leadership and management decision making and fine-tune the direction the organization is taking to reach its goals.
- Establish expectations for leaders to communicate with staff and the community at large about the organization's commitment to diversity and cultural effectiveness.
- Recruit a board that reflects the community's racial and ethnic composition to ensure that community needs, cultural views, and expectations will be represented at the leadership level during strategic planning and throughout the plan's implementation.

2) **Institutional policies and procedures.** Health care organizations take a systematic approach to formalizing their commitment to cultural effectiveness by articulating their vision through written policies, procedures, goals, and practices. They
   - incorporate the organization's commitment to cultural effectiveness in the mission statement;
   - implement policies that promote the collection of race, ethnicity, and language data to measure and support enhanced cultural effectiveness;
   - stratify data by race, ethnicity, and language to identify and address disparities as part of all quality improvement efforts; and
   - provide cultural competency training, mentoring, and coaching for all levels of staff on a regular basis.
3) **Data collection and analysis.** Data related to cultural effectiveness and workforce diversity informs strategic planning and tailors service delivery to meet community needs. Data are also used to identify treatment variations and differences in patient outcomes and satisfaction across groups, and to monitor the impact of cultural effectiveness-related policies and activities on health equity and outcomes. These data can serve to partially fulfill the core meaningful use objectives set forth in the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American

Recovery and Reinvestment Act of 2009 economic stimulus bill). Data are used to

- assess characteristics of the communities served (e.g., patient demographics) and the resources that already exist in these communities;
- evaluate community health needs, a process that the federal government now requires for 501(c)(3) hospital organizations, at least once every three years; and
- prioritize data collection objectives and allocate time for staff to carefully develop the design and implementation of data collection and analysis plans.

4) **Community engagement.** Organizations are more effective when they engage the community in a two-way process to learn, communicate, and share knowledge. This requires establishing relationships that position the community as an active partner in organizational decision making. This is accomplished when organizations

   - engage community leaders to help structure and conduct community health needs assessments;
   - communicate health needs assessment findings to community leaders and others to help interpret and validate findings and receive input on implications for service delivery (Health Research and Educational Trust 2013); and
   - use community input in organizational decision making and ensure that Patient and Family Advisory Councils reflect the diversity of the community.

5) **Language and communication access.** Effective communication is essential to the provision of quality and culturally competent care. Several federal civil rights laws require communication assistance: Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973. In response, organizations are establishing policies and systems to

   - identify and track patients' communication access needs, including preferred language, and to provide appropriate interpretation, translation, and communication assistance services (Gaiser et al. 2015);

- ensure that printed and multimedia materials, as well as signage, are translated into languages commonly found in the communities served and provide patients and family members with timely access to interpreters;
- make information about the availability of no-cost language interpreters and document translation highly visible; and
- establish formal policies to ensure all internal and external interpreters are qualified for their work by setting minimum credential, competency, and/or training requirements.

6) **Staff cultural competence.** Health care organizations implement a range of practices to ensure that patients from all racial and ethnic backgrounds receive optimal patient care. To meet accreditation standards, health care organizations are integrating patient preferences into care delivery and supporting these changes with organizational policies and procedures that enable staff members to fulfill these expectations. The cultural competence of all staff requires continuous learning and professional development and is achieved when organizations
   - individualize the delivery of care to meet patients' cultural needs;
   - provide culturally appropriate food selections, chaplaincy services, and plans of care, including the integration of traditional practices with Western medicine;
   - respect cultural traditions for care delivery, particularly in the areas of end-of-life and patient-provider gender interaction; and
   - support staff members as they learn to confront biases about their peers as well as patients and advance their cultural competence.
7) **Workforce diversity and inclusion.** Health care organizations can address underrepresentation by diversifying their workforce and introducing practices to ensure that employees from all backgrounds have the opportunity to contribute meaningfully to the workplace. They can achieve this goal when they
   - establish relationships with cultural leaders, venues that serve diverse populations, and media outlets—such as non-English newspapers and churches that serve specific ethnic groups—to assist with recruitment;

- require search firms and recruiters used for management and advanced skill positions to present a field of candidates that reflects the diversity of the community; and
- engage in targeted retention and employee career promotion efforts to build and maintain workforce diversity at all levels.

Structured and intentional organization-level interventions are an important step for those who strive to improve quality, remain competitive, and meet regulatory requirements to ensure the health and strength of entire communities. The seven elements outlined here provide a framework for achieving these goals. Organizations that aspire to become culturally effective find it useful to begin with an organizational assessment to provide a baseline and help identify where to focus improvement efforts. It is also important for organizations to remember that becoming culturally effective is an ongoing process. Once implementation efforts have been initiated, these practices need to be continuously monitored for opportunities for improvement, and to hold executive-level management accountable for their success.

BENEFITS TO BECOMING A CULTURALLY EFFECTIVE HEALTH CARE ORGANIZATION

> *We found that current evidence supports the notion that greater workforce diversity may lead to improved health, primarily through greater access to care for underserved populations and better interactions between patients and health professionals.*
>
> —U.S. DHHS Health Resources and Services Administration 2006

It is widely acknowledged that the lack of a diverse health care workforce can be a contributing factor to health disparities. According to the 2004 Sullivan Commission for Diversity in the Health Care Workforce, "The fact that the nation's health professions have not kept pace with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance for tens of millions of Americans" (Sullivan 2004, p. 1). Research shows that culturally effective organizational practices

positively impact quality of care by improving the following for diverse patients:

- *Utilization patterns* increase access to and use of the appropriate health care services at the appropriate time.
- *Patient and family satisfaction* leads to better postvisit or post-discharge patient survey scores.
- *Treatment adherence* generates improved attention to follow-up care and treatment plans.
- *Levels of patient trust* enhance trust in providers. Studies show that this can have a positive impact on treatment adherence and health outcomes.

The American Hospital Association contends that elements of diversity awareness and practice should be integrated with quality measures in the health sector. It states, "Diversity management represents a business requirement that will grow in intensity as the general population, and accordingly the patient population, continues to become more racially and ethnically varied" (Health Research and Educational Trust, Institute for Diversity in Health Management 2011, p. 5).

The health care industry may benefit not only from having greater internal capacity for linguistic resources and cultural competency due to workforce diversity, but also from increased patient satisfaction and improvements in access to care, utilization of services, patient compliance, and health outcomes for minority populations (Cohen, Gabriel, and Terrell 2002). The American Hospital Association notes that workforce diversity, as it contributes to improved patient outcomes, improves the overall performance of the organization, thus putting the hospital at a competitive advantage and benefiting the greater society.

Select employers in New Hampshire understand these benefits and shared their rationale for diversifying the workforce and instituting various forms of organizational change for inclusion. Examples include seeking out and valuing language and cultural skills that match the demographics of the patient population, and working to create a welcoming and inclusive environment for all, with the knowledge that this will improve quality of care. One community health center employer said,

> *So, someone comes here and I ask them in the interview if they're multilingual and they say "yes" . . . they are actually compensated*

at a different percent; they are given additional pay because of the skill set they have.

At the same time, this change process takes time. Leaders can influence the direction of change by setting goals and policies, modeling inclusive behaviors, and working with staff or "lighting the candle" as they learn to adapt to transition. According to one hospital manager,

You need the support of leadership to promote training in cultural competency and acceptance and support for diversity in the workforce. It was my VP who started lighting the candle for me. . . . I also had the support of the hospital CEO and the president and other VPs . . .

SUSTAINING HEALTH AND EMPLOYMENT EQUITY INITIATIVES

This chapter was written two years after the end of the funded partnership initiative, enabling time for perspective and reflection about the impact of this research for advancing the hiring, retention, and promotion of diverse populations in the state. We provide these insights organized by the lessons learned for partnership development and for understanding new relationships between employers and the workforce development system.

Lesson 1: Align Partnership with Existing Priorities for Policy and Practice

Stakeholder interest and engagement in this work is most effective if driven and supported by the coordinated and mutually reinforcing actions of health care employers and employees, community actors, educators and educational institutions, and patients.

IASP's role was to be a facilitator of research and knowledge engagement, standing outside the power structure of local interests. It is possible that due to our neutrality, employers may have been more frank talking to researchers from outside the local area. The partnership and research direction benefited from partners' strong weekly com-

munication and the complement of position, commitment, interest, and knowledge.

One essential component of this work was for the university partner to listen to multiple state actors' insights about the New Hampshire–specific starting point for this work. In collaboration with OMHRA and several other key leaders from health care, community colleges, and philanthropy, an appropriate strategy for state actors was developed, one that they could buy into and advance through each of their own constituency networks. All of this was discussed in the context of Joint Commission requirements and recommendations from other national authorities and experts in the health care field. IASP contributed by doing the crosswalk of national standards to bring existing knowledge and best practices together in a way that would resonate in New Hampshire.

Additionally, it was beneficial to have a "bridge" person—an inside researcher/staff member who could bridge communications and knew all or most state actors, facilitating communication and knowledge sharing, and embedding the work regionally. Some employers and partners were reticent to engage with state government, so the positionality of OMHRA proved challenging at times for local engagement. IASP's role as a nonlocal actor helped facilitate knowledge gathering and reduced some potential barriers to conducting this research.

Lesson 2: Maintain Engagement with Key Champions

The research partners were not always the right messengers or communicators to bring employers into this work, although they were the right partners for identifying the need and conducting the research. This type of sector-based work that ended up focusing on the institutional practices within the workplace requires, for implementation, the right champions or advocates to move it forward. Therefore, OMHRA and IASP learned when to "own" the work or message and when to let go and see that it became embedded as part of the ongoing work of local partners.

Several leaders took on roles that were critical for ensuring the visibility of the work and providing guidance around language and strategies. These included the president of one of the community colleges, the director of a community health center, the director of a local United

Way, the director of the local Area Health Education Center, program officers from two local foundations, the regional officer from the office of apprenticeship training, and two long-term care employers. Without champions, this project would not have achieved the same scale of research or attempted this level of breadth of findings.

Upon reflection, there could have been more time built in to share findings and for stronger relationship building between the partners and OMHRA. At times IASP built the relationship with employers, but OMHRA did not always meet all the employers, simply due to time constraints. This limits OMHRA's ability to continue to actively engage with employer networks. Thus, dedicating resources to build champions during the project is essential, but finding ways to keep those supporters active upon project completion will require additional reflection and new strategies for future partnership projects.

Lesson 3: Create and Provide Clear Guidance for Implementation

While evidence-based research enumerates the benefits of having a diverse workforce, our study revealed that the state's health care providers as a whole did not prioritize this work. They had no clear understanding of the benefits of or guidance for employing and advancing racial, ethnic, and linguistic minorities in the health care professions and were at a loss as to where to start. The culturally effective organization framework responded to this need by providing concrete strategies for implementation. Workforce diversity appears in the framework as one of seven elements, but the overall framework helps employers understand how these elements and strategies overlap and reinforce each other to improve quality and advance equity.

In the future, this type of project would benefit from additional resources to help develop pilot initiatives, with implementation plans at several worksites that put into place structures to support operationalization of the framework. The disciplines of translational science and implementation science remind us that converting theory into practice is challenging even when just dealing with technical change. Here, we are dealing with adaptive change around topics that can cause discomfort for some who are not comfortable acknowledging that there are real disparate impacts of race and ethnicity that require intentional structural

efforts for improvement (Fixsen et al. 2005; National Implementation Resource Network 2016).

The research project contributed significantly to the state's knowledge base, according to both OMHRA and the advisory group partners. The drawback, we learned, is that the research produced an overwhelming amount of knowledge but did not sufficiently plan for a final dissemination and application phase to move the work forward. A key priority for future projects is to provide technical assistance to support health care organizations to operationalize the culturally effective framework in inter- and intraorganizational ways. Quality technical assistance could help employers discover and document more fully the benefits of becoming culturally effective organizations. It would also outline what employers can do and how to do it. Thus, the project generated important awareness about the workplace, workforce, and community health issues, but it fell short in learning how to engage employers in this knowledge to effect long-standing institutional and systemic change.

Lesson 4: Invest in Dissemination to Make Results Last

It took four full years for this research to be conducted and analyzed, and for a first round of research briefs to be written, vetted, and presented to key stakeholders. Additional efforts in formalizing dissemination processes certainly would have broad impacts on the sector and its potential or existing workforce. Efforts to engage health care employers in findings, especially those with some level of institutional influence who will listen and act, has still not occurred at any level of scale.

Today, two years after the project has ended, there is an active legacy. Some highlights are noted here:

- The OMHRA website and the New Hampshire Health and Equity Partnership website post materials created, and information on this topic is updated continuously in ways people can understand.
- The Culturally Effective Organizations Work Group and the Workforce Diversity Work Group of the New Hampshire Health and Equity Partnership draw on the knowledge and materials created and work to further disseminate the learning. Both work

groups seek to engage employers and create resources to support organizations in implementing the framework.

- The Manchester Community Health Center, a lead partner in the HPOP and ERI work, created a Culturally Effective Organizations online tool kit in partnership with the Southern New Hampshire Area Health Education, OMHRA, and the Culturally Effective Organizations Work Group. This was an outcome of its own efforts to pilot implementation of the framework elements in working to create a Center of Excellence for Culturally Effective Care.

This kind of adaptive organizational change requires internal leadership buy-in, institutional commitment, external champions, time, and energy. Without resources to drive the dissemination of this new knowledge, it is hard to change the culture of the environment. Knowledge "sticks" when organizations are actively engaged in learning and testing, and when those who understand the framework educate others. Only then does it start to take hold. Resourcing research translation and dissemination is a challenge and could be built into future research partnership models from the beginning.

EXPANDING THE ROLE OF EMPLOYERS IN WORKFORCE DEVELOPMENT TO BUILD HEALTH AND EMPLOYMENT EQUITY

This examination of the institutional structures, relational factors, and interorganizational relations that underlie health and employment equity suggests that the traditional focus on development of workforce skills and individual efforts to advance in the labor market will not suffice to effect change. A dedicated effort to build leadership understanding and commitment and institutionalize culturally effective organizational change is imperative to enabling the economic advancement of diverse populations into health career pathways.

The framework for culturally effective organizations developed through the HPOG-university-community partnership in New Hampshire gave employers the ability to understand and accept their role in

this larger system. However, more research is required to understand how this organizational change process can be effectively disseminated and implemented, as well as how to measure its direct effect on patients, the workforce, the community, and the health care organization itself. As communities across the United States become increasingly diverse, it is more important than ever to align policy, research, and practice by focusing on the intersections of workforce development, access to quality jobs, upward mobility, organizational performance, and health equity.

Notes

1. The New Hampshire Office of Minority Health and Refugee Affairs (OMHRA) has since changed its name to the New Hampshire Office of Health Equity.
2. Health Care Employer Interviews conducted by IASP researchers as part of the Health Care Employer Research Initiative, 2011–2012.
3. Specific hospital EEO reports, shared with OMHRA by phone and email on July 22, 2011.

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