AN EXPLORATION OF WORKFORCE DIVERSITY MANAGEMENT PRINCIPLES & PRACTICES IN NURSING HOMES

by

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ABSTRACT

There is a lack of research related to workforce diversity (WD) specifically in nursing homes. However, there is a need to understand how WD manifests in nursing homes because nursing homes have several distinct characteristics that are unlike other organizations. The study sought to explore WD among nursing homes. The study aims were to 1) examine how nursing home leaders understand and characterize WD; 2) identify specific diversity management practices currently being implemented in nursing homes; 3) examine how internal factors (i.e. profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition) influence WD management practices; and 4) demonstrate how external factors such as geographic location and community racial composition influence WD management practices. Survey methodology was used to survey 1,111 nursing homes across the Deep South (AL, GA, MS, TN). The 39-item survey included items on participant demographics, racial composition of the staff and residents, knowledge of and attitudes toward WD, culture change adoption, and diversity management practices. The final sample included data for 166 individuals. The sample was predominately Caucasian (90.1%) and 58% female with a mean age of 51 years. The results revealed that managers had positive to neutral attitudes toward diversity and tended to narrowly define diversity using terms more commonly associated with Equal Employment Opportunity/Affirmative Action (EEO/AA) programs, such as race, age gender, and national origin. Recruitment, customer service, and communication/interpersonal skills were

most frequently reported as activities associated with diversity. Human resources personnel, administrators, and corporate officers were most likely to initiate diversity management programs. One in five leaders reported having diversity policies that addressed the concept of diversity beyond EEO/AA requirements. The influence of internal and external factors on diversity management perceptions and practices was examined with regression analyses. Among the internal factors, chain affiliation and increasing levels of culture change adoption were found to be significant predictors of diversity management principles and practices. The external organizational factors did not significantly predict diversity management. The current study has implications for long-term care management practice and policy development, as well as diversity management interventions.

DEDICATION

This dissertation is dedicated in loving memory to my beloved grandmother, Minnie Bell Vinson. *BigMa*, thank you for your unwavering support and prayers throughout our time together on Earth, thank you for being the guardian angel who guided me through the completion of this dissertation process, and most importantly, *thank you for teaching me how to tie my shoes*. I love and miss you dearly.

LIST OF ABBREVIATIONS AND SYMBOLS

AA	Affirmative action
AL	Alabama
ANOVA	Analysis of variance
B	Estimated values of unstandardized regression coefficients in regression and multiple regression analyses
CMS	Centers for Medicare and Medicaid Services
CNA	Certified nursing assistant
df	Degrees of freedom: number of values free to vary after certain restrictions have been placed on the data
EEO	Equal employment opportunity
F	Fisher's *F* ratio: A ratio of two variances
GA	Georgia
LPN	Licensed practical nurse
M	Mean: the sum of a set of measurements divided by the number of measurements in the set
MS	Mississippi
N	Sample size
p	Probability associated with the occurrence under the null hypothesis of a value as extreme as or more extreme than the observed value
r	Pearson product-moment correlation
R^2	Multiple correlation squared
RN	Registered nurse

R-T-D	Reaction-to-Diversity Inventory
RUCA	Rural urban commuting area
SD	Standard deviation: the variability in a given set of values
SE	Standard error: the variability across samples from the same population
t	Student's *t* distribution
TN	Tennessee
WD	Workforce Diversity
α	Cronbach's Alpha: internal consistency or reliability
β	Estimated values of standardized regression coefficients in regression and multiple regression analyses
Δ	Increment of change
η_p^2	Partial eta squared
□	Phi: measure of the strength of association between two categorical variables
χ^2	Sample value of the chi-square statistic
>	Greater than
<	Less than
=	Equal to
#	Number

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

Workforce diversity (WD) is the operative management of various demographic characteristics (such as race and gender) in the workplace (Naswall, Hellgren, & Sverke, 2008). It is a widely researched area; however, the majority of the literature is based on studies conducted in large international organizations (Usry & White, 2000). Within the healthcare industry, the focus in the literature has been on hospitals or healthcare consortiums. There is a lack of research related to WD in nursing homes; yet, there is a need to understand how WD manifests specifically in nursing homes because these facilities have several distinct characteristics that are unlike other organizations. The status of today's nursing home is characterized by racial inequalities in the distribution of staff across the tiers of power and leadership (Harrington, Kovner, Mezey, & Kayser-Jones, 2000; Parker, Friedman, Lach, & Engle, 2006; Singh, Fujita, & Norton, 2004). It is important to examine WD in nursing homes to understand if and how diversity is currently managed in nursing homes and the role that organizational and demographic factors play in diversity management.

Research Objectives

The purpose of this study was to explore workforce diversity among nursing homes in the Deep South. Specifically, the study investigated how nursing home leaders describe and understand workforce diversity and diversity management in their nursing home. The study also identified specific organizational and demographic characteristics that influence diversity management perceptions and practices.

Aim 1. Previous research suggests U.S. employers lack a basic understanding of WD, and there is evidence that nursing home employees associate WD with compliance-based strategies, such as affirmative action or equal employment opportunity (Carrell & Mann, 1993; Vinson, 2011). However, a general understanding of nursing home leaders' knowledge of the concept is necessary in order to design appropriate WD interventions for nursing homes. Therefore, the first aim of this study was to:

1. **Examine how nursing home leaders understand and characterize workforce diversity.**

   H_1: Nursing home leaders will have a narrow definition of workforce diversity; specifically, their scores on the scale measuring WD attitudes will fall within the neutral to negative classification range.

Aim 2. Research suggests that basic diversity training is ineffective, and ongoing diversity management is the best method for cultivating a diverse workforce and fostering positive organizational success (Chavez & Weisinger, 2008; Hays-Thomas, 2004). Because diversity management is a relatively new phenomenon in the diversity literature, little is known about how leaders effectively manage diversity in nursing homes. Furthermore, leaders may narrowly limit diversity management strategies to federal and state-specific requirements. It is possible that nursing home diversity management practices would focus solely on the Centers for Medicare and Medicaid Services (CMS) requirements, which are largely related to communication and language, facility specific in-services, and Equal Employment Opportunity (EEO) requirements. For instance, CMS requires certified nursing assistant (CNA) training in

specific competencies including communication and interpersonal skills, residents' rights, and caring for residents with cognitive impairment. CMS also mandates that CNAs complete a yearly performance review, followed by at least 12 hours of in-service education based on the results of the review. In-services are formalized trainings to foster ongoing competence and skill development in a particular area. CNA in-services may also address any special resident needs specific to the facility, such as training on caring for individuals with cognitive impairments (Centers for Medicare & Medicaid Services [CMS], 2007). While creating WD policies that align with CMS requirements may increase the likelihood of implementation, the current CMS requirements set a low standard for WD. Still, nursing home leaders could expand upon the current requirements to improve WD management. Therefore, the second aim of this study was to:

2. **Explore leader reports of specific diversity management practices currently being implemented in nursing home facilities.**

   This is a qualitative aim, which will address the following research question: Is there a concurrence between reported management strategies and federal and state nursing home facility requirements? Do reported strategies go beyond these requirements?

Aims 3 and 4. Healthcare organizations that have diverse groups across all levels of the organizations are thought not only to have effective diversity management strategies, but they can also provide more culturally competent care and help to improve health disparities and quality of care. The Sullivan Commission (2004) indicated that non-profit healthcare organizations are better positioned to cultivate these diverse workforces because of their mission to benefit the communities they serve. Other studies have also demonstrated that non-profit

nursing homes offer higher quality of care than for-profit homes (Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein, 2001). The Better Jobs Better Care (BJBC) Demonstration project, which was designed to improve direct-care worker satisfaction and turnover through novel changes in long-term care management and policies, provided additional evidence to support higher quality standards and innovation in non-profit nursing homes. This research revealed that non-profit facilities were more likely to implement the demonstration project because they had more external funding resources and higher reimbursement rates due to fewer Medicaid residents (Kemper et al., 2010). Low Medicaid census has also been linked to higher nursing home quality of care and innovation (Castle, 2001; Nyman, 1988; Zimmerman, Gruber-Baldini, Hebel, Sloane, & Magaziner, 2002). Although research has suggested that chain affiliation is associated with lower quality of care (Harrington et al., 2001), Castle (2001) found that nursing homes that were a part of a chain were more likely to engage in innovation due to greater access to capital, economies of scale, and the ability to pilot innovations in other facilities prior to full adoption. Other longitudinal studies on chain affiliation have shown that nursing home quality of care tends to improve over time, as owners often acquire failing or low-quality nursing homes that are gradually restored in quality, with time, from the "resource-rich" sister nursing home facility (Banaszak-Holl, Berta, Bowman, Baum, & Mitchell, 2002).

Richard, McMillan, Chadwick, and Dwyer (2003) examined the relationship between WD and financial performance in banks. The study revealed that racially diverse banks with "innovation-focused business strategies" had a higher return on equity (ROE) and ROE declined as innovation strategies decreased. In the article, the authors address the conflicting WD theories and discuss the importance of WD in context. They go on to say: "Utilizing racial diversity in an inappropriate setting or context may have detrimental organizational effects. Instead, racial

diversity, as a knowledge-based resource, needs to be set in an appropriate context to fully realize the benefits it offers" (pg. 122). Nursing homes are well positioned to benefit from increased diversity because the nursing home industry is adopting an innovative stance to resident-centered care principals and practices, which has also been referred to as culture change.

The basic tenets of culture change include individualized care, empowering direct-care staff members, and changing the physical environment (Kane, Lum, Cutler, Degenholtz, & Yu, 2007). Culture change has also been known to address psychosocial factors including helplessness, lack of meaning, and loneliness, which has been shown to be more prevalent in institutionalized older adults (Kane et al., 2007, Pinquart & Sörensen, 2001). There are a number of different models for culture change that range from minimal staff and environmental changes to complete transformations involving extensive staff training and structural renovations. The ultimate goal is to make the environment as homelike and family friendly as possible (Rahman & Schnelle, 2008).

There are certainly qualitative differences between businesses like banks and healthcare organizations such as nursing homes. The "product" nursing homes sell is related to positive health outcomes and quality of care, which can in turn drive profits and resident/customer satisfaction. However, the basic tenets of WD remain the same regardless of the organizational type. Furthermore, several studies on WD have collapsed data across multiple disciplines including healthcare, manufacturing, military/federal, financial, and insurance industries (Carrell & Mann, 1993; Carrell, Mann, & Sigler, 1996; Ensher, Grant-Vallone, & Donaldson, 2001; Hite & McDonald, 2006).

Additionally, researchers have argued that organizations are often a product of their environment. For example, Brief et al. (2005) found that Whites who live close to Blacks and/or

experience more interracial community discord respond less positively to WD within their organization. Other studies have found similar instances where the outside community affects the overall diversity climate (McKay & Avery, 2006; Parker et al., 2006)**.** Individuals tend to overgeneralize their personal experiences and carry the same perceptions and expectations of individuals of another race into their work lives. Individuals working in communities previously plagued by racial discrimination have a tendency to be more sensitive to racial issues. Nursing home leaders have described employees who grew up in these areas as "rough" and that there may be constant reminders of the oppression and discrimination throughout these cities and in the media. For example, one nursing home leader gave this depiction of the present-day nursing home employee in an area that was once apart of the segregated south.

> *But the people here [have] an edge. […] they'll curse you out really quick [laughs]. […] And I found that out down in the workforce. They were always ready. You know what I'm saying? […] what I found was angry Black people [here]. But it had nothing to do with working; it had all to do with the sixties and what their parents had gone through. Now most of them hadn't gone through any of it, but their parents had. So what I found in this city was Black people […] don't take no mess. They didn't take any mess because they were on edge, always on edge. […] And they family had gone through the sixties and, […] if you turn the TV on any day, anytime in this city, you're gonna hear about it* (Vinson, 2011).

Furthermore, studies related to diversity and community composition have found that employees in racially diverse organizations situated in less diverse communities perceive a more positive diversity climate. On the other hand, racially diverse workplaces surrounded by racially diverse

community members have little to no effect on employee perceptions of diversity climate and relationships with minority coworkers (Pugh, Dietz, Brief, & Wiley, 2008). Moreover, other studies suggest that that perceived community climate predicts workplace turnover for Whites and minorities (Ragins, Gonzalez, Ehrhardt, & Singh, 2012). Thus, it appears that diversity management strategies employed in organizational settings located in diverse communities could include addressing racially biased attitudes that make employers resistant to WD.

A separate racial issue present in the nursing home industry relates to nursing home racial segregation and disparities in care. Using national nursing home data, Chisholm, Weech-Maldonado, Laberge, Lin, and Hyer (2013) investigated whether nursing home racial composition influences quality and financial performance and found that nursing homes with a higher percentage of African Americans had lower costs, revenues, profit margin, pressure ulcer prevention, and restorative care. Nursing homes with moderate to high minority ratios were more likely to be for-profit and have higher Medicaid census, catheter usage, and state surveyor deficiencies and citations than facilities with all White residents. The authors suggest that Medicaid and financial performance may mediate the relationship between resident racial composition and quality of care when the facility is predominately African American, but not when there are little to no African Americans in the facility. Davis, Weech-Maldonado, Lapane, and Laberge (2014) conducted a similar study using national data and also found that for-profit nursing home chains were more likely to have a diverse resident population. In areas with moderate racial segregation levels, increases in minority racial composition were also associated with an increase in Medicare reimbursement rates and market competition.

There is currently a two-tiered nursing home system where the lower-tier nursing homes consists of mostly Medicaid residents, and generally these facilities receive fewer resources,

including fewer direct-care and medical staff. These homes are also more likely to have ownership changes, Medicare/Medicaid termination, and health deficiency citations, all of which are indicative of poorer quality of care. These low-tiered nursing homes are more likely to be located in the Deep South. They are also more likely to exist in rural areas or large metropolitan areas with large minority populations (Mor, Zinn, Angelelli, Teno, & Miller, 2004). Rural nursing home facilities have been showed to provide less quality of care than urban nursing homes even after controlling for state and nursing home size (Lutfiyya, Gessert, & Lipsky, 2013).

African Americans are disproportionately located in lower-tier facilities. The long-term care industry has been slow to change since racial desegregation came into being. Therefore, African Americans continue to reside in racially segregated nursing homes. Although minorities are entering nursing homes at increasingly higher rates, it appears that the range of nursing home options for African Americans to choose from is limited, with over half of all African Americans residents residing in 10% of nursing homes. Moreover, African Americans tend to seek out nursing homes in the communities in which they reside, however, if they reside in neighborhoods characterized by low socioeconomic status, then the nursing home is more likely to be a lower-tier facility. African Americans are also more likely to live in a for-profit nursing home because for-profit homes grew from boarding homes for the poor, whereas non-profit facilities have historically been religious affiliated, only accepting members of a specific church or religious group. Additionally, for-profits may be more inclined to be more inclusive of various demographic groups to maximize profits, especially in areas with increased market competition. Therefore, these low-tier and racially segregated nursing homes lack the resources necessary to attract professional staff, especially those with expertise in management and leadership.

Furthermore, the low-tier and racially segregated nursing homes are less likely to engage in strategic innovation or have leaders who value and effectively manage diversity (Davis et al. 2014; Mor et al., 2004; Smith, Feng, Fennell, Zinn, & Mor, 2007, 2008). Therefore, the following aims were proposed:

3. **Examine how internal factors such as profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition influence workforce diversity management practices.**

   H_2: Nursing home internal factors, such as profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition will predict diversity management practices.

   H_3: Nursing home internal factors, such as non-profit status, chain membership, high Medicaid census, and higher culture change adoption are more likely to have higher scores on the scale of diversity management practices (workforce racial composition will serve as an exploratory variable and no specific assumptions will be made for this variable).

4. **Examine how external factors such as geographic location and community racial composition influence workforce diversity management practices.**

   H_4: Nursing home external factors, such as geographic location and community racial composition will predict diversity management practices

H_5: Nursing home located in urban locations, as well as those with a higher percentage of minority community residents are more likely to have higher scores on the scale of diversity management practices.

CHAPTER 2

LITERATURE REVIEW

This section reviews the existing literature relating to WD in nursing homes and identifies gaps in the current knowledge base. First, WD, Equal Employment Opportunity (EEO), and affirmative action are defined. Following are discussions on diversity-related theories and organizational approaches. Next, the significance of improving WD in healthcare settings is discussed. This is followed by a review of WD-related studies in nursing homes and healthcare settings. The section concludes with a discussion of the nursing home characteristics in the target states sampled in this study.

Defining Workforce Diversity

Hays-Thomas (2004) defines diversity as variation in demographic characteristics that influence approval, performance, liking, and advancement in the workplace. When striving for ideal WD, there are three key areas for examination: 1) does the organization include employees from all populations/groups represented in the community and served by the organization?; 2) is there integration of the diverse expertise and knowledge from these populations throughout the organization?; and 3) are there promotion opportunities, resources, responsibilities, and authority available to all populations and in all levels of the organization? (Sullivan Commission, 2004)

Gardenswartz and Rowe (1994) describe diversity in terms of layers, which include personality, internal dimensions, external dimensions, and organizational dimensions. Personality refers to individual traits, likes/dislikes, or morals. Internal dimensions include attributes that are out of an individual's control, such as age, race, ethnicity, sex, and physical

ability. External dimensions encompass characteristics associated with personal choice, including religion, education, recreational habits, appearance, and geographic location. Finally, organizational dimensions consist of factors controlled by the organization in which an individual works, such as position, seniority, department, or employment location. While most organizations focus their diversity endeavors on the internal dimension, effective leaders in diversity management focus on all four layers of diversity and use the employees' distinctions and similarities to foster a more positive atmosphere and successful business.

Differentiating Workforce Diversity from Workforce Discrimination Law and Policy

Workforce diversity is a philosophical concept from the field of organizational behavior, an ideal for organizations to strive toward to improve their outcomes. In contrast, federal and state workforce discrimination policies and laws have a different goal—protection of vulnerable classes of individuals in the workplace. The outcomes and perhaps even procedures to achieve said outcomes are overlapping, but the two concepts are distinct. There is some evidence that many organizations approach diversity with a narrow focus on complying with regulations rather than more broadly striving for WD (Carrell & Mann, 1993; Carrell et al., 2006; Vinson 2011).

Workforce discrimination laws are under the administration of the U.S. Equal Employment Opportunity Commission (EEOC). The EEOC responsibilities include 1) overseeing laws against WD; 2) investigating, mediating, and settling discrimination grievances; 3) filing lawsuits on the behalf of employees subjected to discrimination in the workplace; 4) offering educational and technical assistance programs to help employers avoid workforce discrimination; and 5) aiding federal government agencies by assisting with their EEO/AA programs, offering guidance and assistance to judges who oversee EEO cases, and adjudicating discrimination complaints against government agencies. According to the EEOC (n.d.) it is:

> Illegal to discriminate against a job applicant or an employee because of the person's race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability or genetic information. It is also illegal to discriminate against a person because the person complained about discrimination, filed a charge of discrimination, or participated in an employment discrimination investigation or lawsuit (para. 1).

Another important component of the U.S. workforce discrimination policy and regulatory environment is affirmative action (AA). AA was initially designed to enforce nondiscrimination and equal employment opportunities during the civil rights movement and refers to formal and informal attempts by institutions to fight discrimination and encourage equality in education and employment. Unlike EEO, AA does not refer to a specific agency or law; instead, AA is a conceptual tool employers can use to accomplish EEO compliance. AA seeks to uncover potential discrimination and implement policies to eliminate any future discrimination. AA is a proactive approach to eliminating discrimination by examining if EEO is present in the workplace. If EEO is not present, AA allows for plans and policies to be put into place in a timely manner to ensure workplace equality. Thousands of employers have voluntary AA programs; however, AA programs are required when they are court-ordered (usually after an employer is found guilty of discrimination) and for government agencies or businesses contracting with government agencies (Crosby, Iyer, Clayton, & Downing, 2003). Numerous lawsuits claiming that AA plans place Whites at a disadvantage for placement and promotion have cast a negative light on the usefulness of AA, and several states have subsequently banned AA in the public sector (Hanson, 2009).

The results of a longitudinal study conducted by Carrell et al. (2006), indicated that about half of human resource professions currently consider WD, EEO, and AA as synonymous terms; these results were not significantly different from responses to the same question in a previous survey in 1992 (12 years prior). Based on the results of the surveys, the authors identified race, culture/ethnicity, gender, age, and national origin as primary EEO/AA characteristics because they were the most commonly identified components of WD. Religion, language, physical ability, regional origin, and sexual orientation, also commonly cited, were identified as secondary characteristics. Similarly, Vinson (2011) conducted a qualitative study with nursing home leaders and reported that the leaders largely defined WD in terms of race and antidiscrimination and did not view WD as a specific value to the organization. For example, when asked to discuss specific diversity policies one leader responded,

> "*It is our policy not to discriminate because of race, religion, national origin, all of those things that are protected by law and we are committed to that kind of policy. So, that's where the diversity comes from, I think is in compliance with the EEO policy"* (pg. 69).

In sum, these studies may indicate a tendency on the part of many organizations to narrowly define diversity in legalistic terms. If organizations and the leaders who run them are to move to a broader approach to conceptualizing diversity, truly aspiring to be inclusive and strive for ideal diversity in the workplace, then the current conceptualizations of leaders must be carefully examined. Any intervention to help nursing homes improve their diversity would have to include having leaders buy-in to the broader need to promote WD beyond regulatory requirements, and so more broadly understanding how leaders conceptualized WD would be key.

Theories Suggest Diversity Can Affect Workgroup Outcomes

There are a number of different theories on diversity, all derived from basic in-group/out-group psychology. The three most commonly cited theories are 1) information and decision making theory, 2) social identification and categorization theory, and 3) similarity/attraction theory.

Information and decision making theory. Information and decision making theory predicts a positive relationship between diverse workgroups and outcomes. In terms of delivering information and making decisions within groups, this theory posits that diverse workgroups possess more ingenuity, ideas, and knowledge (Cox, Lobel, & McLeod, 1991; Pitts & Jarry, 2007). Although it may be more difficult to interact and collaborate with diverse group members initially, Sulman, Kanee, Steward, and Savage (2007) found that in the midst of the disagreements there is originality and novelty. The influx of information that emerges from the diverse workgroup can compensate for any adversities that arise within the workgroup (Joshi & Jackson, 2003). One caveat of the information and decision making theory is that the research on the theory is not based on racial diversity. Studies using this theory examined banking and technology industry workgroups with members varying in education, age, experience, and levels of expertise and found that the diverse groups were more innovative (Ancona & Caldwell, 1992; Bantel & Jackson, 1989).

Social identification and categorization theory. Social identification and categorization theory posits that in order to maximize self-esteem, people make comparisons with others. These comparisons lead one to develop a social identity, which is defined as one's membership in a given group of categories. People tend to hold their own categories in high regards, while

deeming all others as negative. People will often stereotype out-group members as being less dependable, truthful, obliging, or intelligent.

This theory is relevant because social identities and group categories can develop based on race and job status. In the nursing home, bonds between employees form, in part, along racial lines. For example, certified nursing assistants (CNAs), also known as direct-care workers, report being more comfortable working with co-workers of the same ethnic group (Foner, 1995). This causes racial tension between group members, which can be reflected in the CNAs' everyday duties and care for the residents. When nursing homes first developed, many of the CNAs were immigrants and minorities from secondary labor markets. Such workers were characterized by job instability and low social status and income. These same features are present in today's nursing homes. Thus, in addition to racial tensions, the hierarchical structure of the nursing home sets nurses against the CNAs, and subcultures are created based on occupational roles and status (Berdes & Eckert, 2001).

The social identification and categorization theory is also important to understand from a leadership perspective. Some supporters of this theory believe that diverse groups lead to negative outcomes because the number of out-group members outweighs the in-group members, which may cause stereotyping and problems with mistrust, communication, and teamwork. However, the diversity management literature acknowledges the importance of this theory for leaders, in that effective diversity management is dependent upon leaders who embrace, but do not ignore differences within workgroups. Group membership defines one's social identity, which is directly related to self-esteem. Thus, it is important to embrace each employee's social identity in order to make them feel valued and to benefit from the diverse perspectives they bring to the workplace (Chrobot-Mason & Ruderman, 2004).

Similarity/attraction theory. Similarity/attraction theory suggests that people with similar characteristics, especially demographic ones, tend to appeal to others with comparable qualities. Persons from similar backgrounds are likely to share common interests, which make them more comfortable with one another while working towards a common goal. Furthermore, such individuals opt to interact with similar people, and they are more likely to reinforce their in-group member's ideas. Thus, the similarity/attraction theory posits that faulty work process is the likely outcome in diverse workgroups (Pitts & Jarry, 2007).

Conclusion. These theories are useful in predicting how leaders can help overcome barriers to work process and utilize individual differences, as well as predict what kinds of outcomes diverse work groups will have. Leaders who effectively manage diversity and are willing to embrace cultural differences are more likely to have positive outcomes. Based on these three theories, it might be expected that nursing homes with higher WD will have leaders who have more positive attitudes toward diversity and engage in more diversity management practices than those with a lower workforce racial composition.

Making the Case for the Need to Increase Workforce Diversity in Nursing Homes

Increasing minority patient base. The demographics of the U.S. workforce are rapidly changing. Currently, minorities account for approximately 34% of the U.S. population. By the year 2050, the African American population is expected to double, while the Asian and Hispanic populations will triple (U.S. Census, 2008). Certain U.S. areas are referred to as "minority majority areas" because three in five individuals seen in healthcare settings represent a racial/ethnic minority group, and these areas are expected to become 100% multicultural within the next five years. Additionally, the older adult population is rapidly increasing and becoming more ethnically diverse. Between the year 2000 and 2010 the number of persons aged 65 and

older grew by 15%. By 2050, it is estimated that the older adult population will nearly double by increasing to 88.5 million, a figure accounting for 20.1% of the entire population. Minority elders will also see an increase in their respective populations, as this group is expected to increase from 20% to 42% of the total older adult population over the next four decades. Furthermore, minorities, African Americans in particular, are using nursing homes at a higher rate than Whites (Smith et al., 2007, 2008), and nursing homes that are not diverse will lack the necessary policies, procedures, and service delivery systems to appropriately care for minority residents (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Thus, there is a strong need for the U.S. healthcare industry to respond not only to the increasing number of minority patients, but also to reflect the patient population demographically.

Increasing immigrant minority workforce base and the associated healthcare worker shortage. It is also important to recognize the variation within ethnic minority racial groups because research suggest that immigrants and foreign workers have been identified as possible employees to address long-term care worker shortages (Priester & Reinardy, 2003). Moreover, groups such as the Refugee Healthcare Partnership specifically train immigrants for positions as CNAs (Stovall, 2005). Currently, seventeen percent of nursing home CNAs were born outside of the U.S., and immigrant CNAs are more likely to work in a hospital or nursing home than any other care facility. The top five areas where immigrant direct-care workers migrate from include the Caribbean and Atlantic Islands (29%), Mexico and Central America (21%), Asia (19%), Africa (12%), and Europe (10%; Martin, Lowell, Gozdziak, Bump, & Breeding, 2009). A national study of the immigrant CNA population found that foreign-born CNAs are older, more educated, predominately reside in metropolitan areas, and receive slightly higher wages than domestic-born CNAs. The immigrant CNA population reports significant

difficulties with communication with staff and residents due to language barriers, and they also report having more experiences of discrimination based on race and ethnicity than non-immigrants (Khatutsky, Wiener, & Anderson, 2010). Immigrants are also more likely to report greater perceptions of workforce racial discrimination (Allensworth-Davies et al., 2007; Berdes & Eckert, 2001).

Kelly (2013) reported on a case study of a teaching hospital in Brooklyn, NY with a workforce that was 90% minority, and mostly foreign-born. Demographics, culture, language, and level of assimilation were identified as barriers to organizational change and quality of care in this case study. In this particular hospital, the physicians were more likely to be Asian and African, the students and medical residents tended to be Asian, and the nursing and direct care staff were predominately Caribbean and African. The author suggested that the hierarchies and bureaucracy that exist in healthcare systems are often exacerbated when workers from the same country of origin are clustered by profession/discipline. This may be because the unspoken messages and assumptions made in communicating language are as important as the spoken words. In some countries conversations are strongly influenced by background information, nonverbal communication, and internal meanings. Other countries may focus less on the context of the conversation and more on explicit statements, feelings, and intentions. Therefore, the delivery of language and the perception of the message and the communicator all factor into communication between individuals of different cultures, especially in healthcare. Rather than assimilating to a particular work approach or leadership style of the predominate culture, the study suggests that foreign-born healthcare workers in organizations with high amounts of clustering by profession tend to rely more on their own cultural norms in the workplace. Clashes may arise between workgroups from collectivistic and individualistic cultures, especially related

to socializing in the workplace. Additionally, issues of social class may unfold through various occupational roles.

Kemper and colleagues (2010) developed the Better Jobs Better Care (BJBC) Demonstration project to improve direct-care worker satisfaction and turnover. Although the project was unsuccessful in improving direct-care worker's perceived job quality and turnover, there were a number of important outcomes from this research. The qualitative results from the BJBC demonstration revealed nursing homes in Black communities tend to employ more African Americans in supervisory and leadership roles and Black immigrants in CNA positions. The study also showed there was discrimination within immigrant groups based on variables such as skin color or the size of a particular group's native land. Verbal and non-verbal communication (e.g. accent, tone of voice, fluency, and body language) contributed to the language barriers that existed within the facilities, which led to tension and confusion. The researchers also found that language policies prohibiting the use of languages other than English while working exist in nursing homes, despite the language preferences of the residents. Such policies were put in place to prevent the discomfort that often arises when immigrant CNAs congregate and speak their native language in front of English-speaking employees, residents, and family members. Unfortunately, while these issues affected the overall nursing home experience the employees reported these issues were seldom addressed (Parker et al., 2006).

Allensworth-Davies et al. (2007) studied perceived cultural competency and job satisfaction among racially and ethnically diverse CNAs. The results revealed that a greater perception of organizational cultural competency was the strongest predictor of positive job satisfaction. The results also revealed that in comparison to U.S.-born CNAs, foreign-born (i.e. Asian, African-born Black, Haitian-born Black, Latino, and Hispanic) CNAs were more likely to

perceive higher autonomy and intrinsic feedback, such as positive feedback from a resident or family member. The authors concluded that when foreign-born CNAs do not receive approval and support from their managers and peers, they might be more likely to seek nontraditional means of performance appraisals. Minority CNAs reported higher culture competency when they perceived their facility as a comfortable work environment. Cross-cultural communication and appropriately responding to reports of racial discrimination were positively correlated with a comfortable work environment. Whites' perception of the level of cultural competency within a facility was more positive than non-Whites, which is consistent with previous qualitative studies (Berdes & Eckert, 2001; Mercer, Heacock, & Beck, 1993; Parker et al., 2006).

In conclusion, there is a growing foreign-born CNA population due to the healthcare workforce shortage. The immigrant subcultures that develop add a layer of complexity to the intricate racial milieu that already exists. Little attention has been given to the discrimination that occurs between and within these racial subgroups in long-term care settings. Yet, CNAs' job satisfaction decreases when the organization is perceived as lacking in cultural competency. Thus, there is an increasing need to improve WD in nursing homes in order to better understand and address the needs of these racial subgroups.

Workforce diversity will reduce health disparities. The workplace has long been the setting to address the many societal inequalities that exist within the workplace; thus, targeting the workplace to improve inequalities in healthcare appears to be ideal (Berry & Bell, 2012; LaVeist & Pierre, 2014; Nivet & Berlin, 2014; Phillips & Malone, 2014; Williams et al., 2014). The need to increase the number of minorities in healthcare stems from three major disparity concerns. First, studies suggest that there are improvements in patient satisfaction, compliance, and quality of care when a health provider is of the same ethnicity and/or speak the same

language as the patient (Cohen, Gabriel, & Terrell, 2002; Betancourt et al., 2003; Gillis, Powell, & Carter, 2010; Institute of Medicine [IOM], 2008). Second, increasing WD will improve patient access to care because underrepresented minority providers tend to practice in underserved areas thus improving access for vulnerable minorities patients (Garcia, Paterniti, Romano, & Kravitz, 2003; Gillis et al., 2010). Finally, the Sullivan Commission's (2004) report on diversity in the healthcare workforce indicated that WD was essential for improving cultural competency, as diverse healthcare providers have the ability to teach and provide more culturally competent care than non-minority health providers.

The Office of Minority Health developed nationwide criteria for culturally and linguistically appropriate services (CLAS) in healthcare, which specifies 14 standards on policies and practices to develop culturally appropriate healthcare systems. The three CLAS themes are culturally competent care, language access services, and organizational supports for cultural competence. The goal of CLAS is to improve minority access to healthcare and eliminate minority health disparities. Weech-Maldonado and Dreachslin (2012) developed the Cultural Competency Assessment Tool for Hospitals (CCATH) to help organizations measure their compliance to the CLAS standards. The CCATH is a 31-item measure that includes five major sections: culturally competent care; human resource management; interpreters and translators; leadership, strategy, and climate; and workforce racial/ethnic composition. Field-testing revealed the CCATH tool has good psychometric properties and has implications for use among hospital administrators, policy makers, and researchers.

Dotson and Nuru-Jeter (2012) made the controversial argument that the current health care system is designed to create healthcare disparities. The authors conclude that when outcomes are poor within a given organization one need only to look to the leadership for the

causes and solutions. Thus, quality of care has a direct association with "how well leadership and management practices are aligned to understanding the organization's health and healthcare disparities" (p. 38). Employers and insurance providers are arguably healthcare organization's largest consumers. These top consumers will require a greater justification from the leadership regarding why culturally competent care should be implemented and financed. The authors contend that culturally competent care should be a "business phrase" rather than simply a healthcare buzzword. Thus, they proposed three strategies to leverage healthcare leadership's investment in diversity: 1) provide more empirical evidence supporting the relationship between diversity and outcomes, including diversity measures and best-practices associating diversity leadership with health disparities; 2) associate diversity management with financial outcomes; and 3) require leadership to carry out diversity management practices and make this its own performance measure/indicator.

In summary, WD has been identified as a means to improve health disparities. Studies have shown that WD strategies can improve access to care, patient outcomes, and cultural competency. Nationwide standards are being created to measure, promote, and fund culturally competent healthcare. However, there is still not a strong business case for WD among healthcare leadership, and health care industry executives have yet to embrace diversity as a managerial tool to improve performance and outcomes. More research is needed to support the relationship between WD and health and financial outcomes.

Workforce diversity makes good business sense. There is an extensive amount of research in the business literature that suggests diverse senior level management teams have better outcomes than homogeneous workgroups (Dalton, 2005), and companies with a strong commitment to WD have better financial performance than their matched counterparts (Slater,

Weigand, & Zwirlein, 2008). While diversity research in healthcare is much more limited, several studies have reported on the economic benefits of having a diverse healthcare workforce. Hampers, Cha, Gutglass, Binns, and Krug (1999) found that hospitals spend more time and money on laboratory testing and diagnostic evaluations when their providers do not speak the same language as the patients. Given that minorities may seek out service providers who are similar to them, WD also provides healthcare systems access to minority patient markets (Betancourt, Green, & Carrillo, 2002). As previously mentioned, non-diverse workforces are associated with poor health outcomes, and for employers, poor health leads to lost productivity, absenteeism, and high health insurance premiums. The business community has become more cognizant of the impact that diverse healthcare workforces have on their financial performance, as many employers seek to purchase health plans that can offer a diverse pool of providers for their diverse workforce (Sullivan Commission, 2004). Thus, the healthcare workforce needs to be able to respond to the increasing need for a more diverse workforce in order to protect their bottom line.

The lack of minorities in nursing home leadership can disrupt work process and lead to conflict and racial tension. Minorities are currently disproportionately represented in the healthcare industry. Studies suggests that being a nursing aids is one of the most common professions for all African American women (Berry & Bell, 2012), yet minorities account for less than 2% of all senior-level healthcare management positions (Betancourt et al., 2003). In nursing homes, Whites hold the majority of the leadership positions, while minorities comprise the majority of the CNA staff positions (Parker et al., 2006). Among 258 nursing home administrators sampled in a study on determinants of pay satisfaction, only six were minorities, and while these minorities had higher salaries, they received fewer and smaller bonuses than

non-minorities (Singh et al., 2004). Diversity within healthcare facilities is more likely to occur in the lower levels of the organization. For example, while minorities make up approximately 25% of the labor force, they account for over half of the direct care workforce, which largely consists of nursing home CNAs. Nationally, the nursing home direct care workforce is 51% White, non-Hispanic, 35% African American, 10% Spanish, Hispanic, Latino, and 4% other (Smith & Baughman, 2007). The percentage of minority direct-care workers, specifically in nursing homes, varies by geographic location, as some nursing homes have reported rates of minority CNAs as high at 90-100% (Vinson, 2011).

The underrepresentation of minorities in leadership positions and the overrepresentation in lower-level staff positions creates a power imbalance, which can create racial tension that impedes productivity and lowers the quality of care provided to the residents (Dreachslin & Hobby, 2008; Mercer et al., 1993; Otto & Gurney, 2006). Minorities in non-diverse companies are often less motivated and do not aspire to their full potential because they do not see opportunities for minorities to excel in the company, nor can they perceive themselves as potential leaders of a majority-led company (Cox, 1994). Moreover, minorities in token leadership roles are often marginalized, confined to conventional roles, and underestimated. The heightened visibility of token members also brings attention to intergroup differences, which can cause polarization (Cox, 1994; Karsten, 2006). The lack of minority leadership representation may be particularly impactful in nursing homes because these organizations typically have a distinct hierarchal structure in which decision making for the entire nursing home occurs in senior management positions with very little input from lower levels (Berdes & Eckert, 2001; Mercer et al., 1993).

In a review of the literature on organizational inequalities, Berry and Bell (2012) posited that organizations tend to create and reinforce social class hierarches. Workplace inequalities are manifested through variability in flexibility, autonomy, required skill education and levels, benefits, and pay within the organization for certain groups of employees. Additionally, once a gender or racial group dominates a particular occupation and societal and/or organizational assumptions are created, the appropriateness of other groups working in this field are often called into question. The authors also argue that the federal government has played a significant role in perpetuating workplace inequalities throughout the course of history, particularly within the direct care workforce and other "caring" work position, which have disproportionally been held by minority women. The Fair Labor Standards Act (FLSA) of 1938 established the standard workweek, minimum wage, and overtime for U.S. employees. The initial act exempted domestics, agricultural workers, as well as nursing home employees. Nursing home employees were included under FLSA in the 1960s. However, even today, home health aids, certified nursing assistants, and domestic sitters/companions providing in home care are exempt from the minimum wage and overtime requirements under certain conditions (U.S. Department of Labor, 2013).

Sulman and colleagues (2007) reported that healthcare workers often feel their organization discriminates against minorities, and well over 70% of CNAs report experiencing blatant racism on the job from residents, family members, and/or co-workers (Berdes & Eckert, 2001; Mercer et al., 1993). What is more, nursing home administrators are not always aware of the racial issues in the workforce, as evidenced by the finding that lower-level workers often express problems as being more severe than depicted by administrative staff (Mercer et al., 1993). Several other authors have detailed nursing home CNAs' experiences with racism (Berdes

& Eckert, 2001; Jönson, 2007; Mercer et al., 1993). However, little is known about nursing home leaders' knowledge of racism across their organization, their attitudes toward such racism, whether knowledge and attitudes vary by the leaders' own race, and minority leaders' personal experiences with racism and how these experiences might affect their leadership practices.

While there is a disproportionately high number of minority direct care workers, minorities are inadequately represented in healthcare leadership. The racial power imbalances create additional tensions in an environment that is already plagued by hierarchical bureaucracy and racial discrimination. Social norms can lead to negative stereotypes about direct care workers that appear to devalue the work these individual provide. Promoting WD can help bridge the racial divides in leadership and improve the organization climate in nursing homes.

Diversity management is more effective than basic diversity training. If the number of minority workers in nursing homes is to be increased, there must be policies in place to optimize their contributions. Over 70% of American organizations report having some type of diversity training program, and each year, American companies spend over $8 billion dollars on such interventions (Chavez & Weisinger, 2008; Hite & McDonald, 2006; Bierema, 2010). However, less than one-third of workers believe that their organization's diversity training initiatives are effective (National Urban League, 2004), a statistic that particularly highlights the low return on investment from current diversity training programs. Basic diversity training programs are designed to promote awareness and understanding of diverse groups in an effort to increase group cohesiveness and productivity in the workplace. Years of study have led researchers to conclude that these training programs may be counterproductive, in that they can actually create backlash, hostility, and competition (Chavez & Weisinger, 2008; Beaver, 1995).

More recent reviews of diversity training suggest that diversity training may have some positive implications for organizations, but within specific contexts. In a study of healthcare organizations in the UK, researchers found minorities who received little to no diversity training within a 12-month period were more likely to report experiencing racial discrimination than those who had received diversity training. However, Whites reported little to no experiences with discrimination regardless of the amount of training received. Job satisfaction significantly decreased for individuals experiencing discrimination. The study also found that for individuals who experience discrimination, job satisfaction decreased as the number of minority employees increased and when there is a lower organizational prevalence of discrimination. The authors conclude that although previous research on diversity training indicates its ineffectiveness, a decrease in perceived discrimination may be one positive, and very important outcome (King, Dawson, Kravitz, & Gulick, 2012). A meta-analysis of diversity training revealed that the trainings have a small to moderate effect on outcomes. Diversity trainings are most effective in improving knowledge- and skills, but not attitudes, self-efficacy, and motivation. The authors indicated difficulties related to measurement and the feasibility of attitude change may influence these results (Kalinoski et al., 2013). Other studies indicted that diversity trainings that are integrated into a system of diversity programs that focus more on inclusiveness across groups, rather group-specific differences, have more favorable outcomes in the literature. However, there is very little empirical research on integrative or inclusive approaches to diversity training (Bezrukova, Jehn, & Spell, 2012).

Research suggests that managing for diversity is a better alternative to diversity training. However, many EEO/AA programs are also incorrectly identified as diversity management strategies (Thomas, 1990). Managing diversity goes above and beyond generating awareness of

diversity issues; it focuses on "building a culture that draws out and acts on the unique perspectives a diverse workforce can bring to organizations" (Chavez & Weisinger, 2008, p.332). Diversity management is voluntary, structured, and deliberate. It involves an organizational commitment to be inclusive to all minority groups, through recruitment and retention, outreach, teamwork, appreciating differences, initiatives, policies, and programs (Gilbert, Stead, & Ivancevich, 1999; Kellough & Naff, 2004; Thomas, 1990). Diversity management strategies can include "performance evaluations, type of sanctions applied, opportunities to develop skills in developmental programs, diversity specific training, creating support networks, mentoring programs, advertisement campaigns, [and] marketing strategies to set up diverse team projects in order to address a diverse customer-base" (Tran, Garcia-Prieto, & Schneider, 2010, p. 164). Researchers suggest that diversity management is the catalysts for culturally competency in healthcare settings (Dotson & Nuru-Jeter, 2012).

Leaders within the organization have a key role in WD management because their attitudes, involvement, and concordance set the stage for organizational change. Diversity initiatives are most effective when they come from upper management because they have the authority to develop and implement organizational policies and procedures (Dansky, Weech-Maldonado, De Souza, & Dreachslin, 2003; Sulman et al., 2007). However, in order for WD to be effective, leaders must value diversity and see it as a benefit to the organization, rather than a predicament to be solved (Muller & Haase, 1994). There are several key facets to effectively managing diversity. The first component of diversity management is that leaders must recruit and retain a diverse workforce at all levels of the organization. Minorities in senior positions are especially beneficial when developing new diversity strategies. Second, an initial needs assessment is critical for identifying specific diversity issues germane to the organization. Third,

training that results from the assessment should emphasize team building and group process, in which the teams utilize each group members' perspectives and skills in order to improve performance. Fourth, a post-program evaluation should be conducted to assess what, if any, organizational behavior and organizational change resulted from the program's implementation (Chavez & Weisinger, 2008; Muller & Haase, 1994).

In brief, while basic diversity awareness trainings are offered frequently, much of the research literature suggests these trainings have poor outcomes. However, there is some evidence that suggests diversity training may be helpful in certain contexts. Managing for diversity appears to be a more effective approach that can also lead to improvements in culturally competent care. However, the degree of diversity management will only stretch as far as the healthcare leaders' vision and value of diversity within their organization.

Workforce Diversity and Related Research in Nursing Homes and Other Health Care Settings

Previous research on workforce diversity in health care. Most of the research conducted on WD has been in hospitals or healthcare organization consortiums. For example, Muller and Haas (1994) developed a theoretical framework and recommendations to increase WD using case study data from managers and board members. The authors directly relate the level of structural integration to leadership support. They found that the health service institutions studied were not effectively managing WD. The organizations were described as pluralistic, meaning they were somewhat heterogeneous with partial structural integration but primarily relied on compliance-based diversity programs and procedures. These findings are consistent with other research showing that many healthcare organizations are in compliance with federal regulations for affirmative action, yet they are not proactive in managing WD (Weech-Maldonado, Dreachslin, Dansky, De Souza, & Gatto, 2002). These studies may have

implications for the entire healthcare system; however, there is no research evidence to support the manner in which nursing homes manage WD. Additionally, the Muller and Haas (1994) article states that the participants were from "multi-institutional" healthcare systems and were not specific to nursing homes.

Aries (2004) conducted qualitative interviews to examine WD in hospitals and integrate the perspectives of upper and mid-level managers, patients, and frontline workers on service delivery to minorities by diverse employees. The study revealed inconsistencies in how the groups understood diversity and culturally competency, and when diversity management was present, there was no uniformity among approaches throughout the hospital departments. The managers focused more on environmental/physical and policy and procedural modifications to improve cultural sensitivity. Meanwhile, the frontline staff members were unsure of their role in providing culturally competent care because they received little to no training. The frontline workers indicated the staff's racial prejudices resulted in reduced quality of care, as well as discrimination and preferential treatment toward patients and other frontline workers. Similarly, the patients perceived they received preferential treatment from frontline staff of the same ethnicity.

In terms of language, the managers were more concerned about having translators who were representative of the immigrant patient population, either through multilingual employees, family members or language banks. The frontline staff and the patients expressed their dissatisfaction with the translation services. Bilingual staff also working as translators found the task burdensome and time-consuming. Meanwhile, patients expressed a need for translators around the clock, as well as translators with the ability to explain medical terminology.

Additionally, the frontline staff expressed differing opinions on whether language policies were needed to oversee the use of other languages among employees (Aries, 2004).

The managerial staff appeared to be oblivious to the racial issues that developed from having a diverse workforce, which served as a source of discontent between the mangers and frontline staff. Only 3 out of 23 of the managers believed racial conflict was a problem in their hospital. Instead, the managers reported that the perceived racial issues were isolated and individual/personal in nature. On the other hand, the frontline staff reported the managers were simply not involved in direct-care enough to be aware of the racial issues. Although this study clearly illustrates the complexity in understanding diversity in healthcare settings, the study design limits generalizability, as the participants were all employees in New York hospitals. Furthermore, while the patients and staff groups were ethnically diverse and representative of the population, the authors failed to report any diversity information on the management sample. Therefore, inferences cannot be made about any differences between among managers of varying ethnicities (Aries, 2004).

Another study surveyed hospital managers in Pennsylvania to investigate the diversity management policies and procedures, diversity leadership, as well as market (e.g. urban/rural location, community racial composition, income, etc.) and internal (e.g. profit status, facility size or type, and healthcare system status) factors to diversity. This study developed a 56-item survey to measure diversity management that included six specific subscales: planning, stakeholder satisfaction, diversity training, human resources, healthcare delivery, and organizational change. They found that diversity implementation could fall along a continuum, from only complying with affirmative action requirements to full-fledged diversity implementation and value. However, the majority of the hospitals reported that equal opportunity employment regulations

were the main reasons for any current diversity initiatives they currently in place. While half of the respondents reported including diversity in their missions statements, approximately 25% or less of the respondents reported providing diversity training for employees, diverse interview teams, free foreign language courses, or assessing employee satisfaction surveys among races. The study did not find significant differences in diversity management practices based on market or internal factors. (Weech-Maldonado et al., 2002).

Dansky and colleagues (2003) used the same six-factor scale to develop a survey to examine the relationship between diversity management and sensitivity to diversity. The authors surveyed 203 senior hospital managers in Pennsylvania. The authors concluded that organizations with external, or market-driven, strategies were more likely to engage in diversity management compared to others with an internally focused strategic orientation. They also found that diversity sensitive orientation (DSO), defined as sensitivity to cultural diversity, moderated the relationship between organizational strategy and diversity management practices. More specifically, when DSO organizations focus on the external environment, they were more likely to actively manage diversity than organizations with an internal focus. Furthermore, the authors concluded that while strategy does influence workforce diversity leadership**,** it is DSO that can forecast the degree to which a hospital will actively take on WD practices.

Weech-Maldonado and Dreachslin (2012) use the CCATH survey previously described above to assess the relationship between organizational and market factors among California hospitals. Increases in cultural competency were associated with non-profit status, teaching hospitals, larger facility size, system membership, as well as increases in managed care patients and diversity of patient census. However, after controlling for market factors, only profit status, higher patient diversity, and market competition significant increases cultural competency scores

on the CCATH. The results suggest that the hospitals with a more diverse patient population are attuned to the specific cultural needs of their patients, and perhaps patients who receive care in less diverse facilities have limitations regarding access to care. Moreover, while cultural competency increases with market competition, some, but not all, hospitals use cultural competency to bolster business in diverse markets. The authors conclude that for-profit hospitals might adopt more culturally competent practices if the facilities could demonstrate such practices would lead to competitive advantages either from the standpoint of attracting more patients or retaining a productive workforce.

Other research on WD has specifically focused on culturally and linguistically appropriate care to individuals with limited English proficiency (LEP). Whitman and Davis (2009) conducted a survey of 1,976 registered nurses (RNs) in the state of Alabama to explore their perceptions of the culturally and linguistic appropriate training and resources available in general medical and surgical hospitals. Overall, the study found that RNs perceive Alabama hospitals to be average, at best, regarding providing culturally and linguistically appropriate care to patients with LEP. According to the survey results, approximately half of the hospitals have a trained interpreter available for LEP patients, and even fewer (35.7%) have received training on how to work with an interpreter. The results also revealed inconsistencies in the amount of resources and training provided to RNs across hospital settings, which may suggest that there are disparities in care.

The same authors conducted a similar study with general medical and surgical hospitals' chief executive officers (CEOs). The study revealed that 47% of the respondents reported having a trained interpreter employed in their hospital. Hospitals with interpreters were more cognizant of their community and its needs, and culturally appropriate care was more likely to be

highlighted in their mission statements. For instance, the CEOs in these hospitals were over four times more likely to state that the increasing amount of immigrants in the area would create a "cultural problem" for their facility and three times more likely to report monitoring their service area in order to gather information on new cultural groups that were moving into the service area. Furthermore, CEOs who understood their role to be that of a visionary and steward of the mission were also more likely to employ trained interpreters (Davis & Whitman, 2008).

Another study surveyed the human resource directors (HRDs) of the same Alabama hospitals. Comparable to the CEOs, nearly 45% of the HRDs reported having a trained interpreter on staff. The most commonly cited reason for not having an interpreter was that LEP patients bring friends or family members along with them to serve as translators. The HRDs heavy reliance on family members is especially concerning given previous literature suggesting the need for translators trained to interpret medical terminology. Additionally, patients and the family translators may be uncomfortable discussing personal healthcare information (Aries, 2004). The study also found that three in four hospitals actively recruit for racially diverse employees, and 73% of the HRDs reported having ethnic minorities in leadership positions. The hospitals with racial diversity in leadership were more likely to recruit for diversity in racial backgrounds and language, as well as partner with organizations that provide resources and services to minority groups, which is consistent with previous research suggesting that leaders who value diversity will be more active in diversity management (Whitman & Valpuesta, 2010).

These studies of WD in healthcare have significantly contributed to the cultural competency and WD in health care literature, and they also establish a need for future studies in other types of health care facilities, such as nursing homes. The proposed study will add to the

literature by examining how the race of leaders affects their perceptions of diversity management in their facilities.

Previous research on race and power in nursing homes. It is assumed that to date, there has been no published research on WD in nursing homes, based upon thorough searches of the scholarly literature using multiple databases (ABI/INFORM Complete, Academic Search Premier, Business Source Premier Pubmed, PsycINFO, etc.). To the best of my knowledge, my unpublished thesis research is the only work that specifically addresses WD in nursing homes. Therefore, I will next review the body of published literature that examines the role of race broadly in nursing homes (most of which is about the experience of racism between residents and nursing assistants), and then close with a review of the results of my previous thesis on WD, race, and power in nursing homes.

Grau and Wellin (1992) conducted a qualitative study using two skilled care facilities in Wisconsin. One of the facilities included residents and CNAs of the same racial and ethnic background (Polish), while the other facilities employed Black and other minority CNAs who cared for predominately White residents. Subcultures based on culture, occupational roles, and socioeconomic statuses were present in the racially diverse facility. The social distancing between the staff and the residents/family members resulted in more complaints to nursing home administrators and state regulatory agencies. This home implemented defensive regulatory-compliance strategies to protect their reputation and prevent regulatory interventions from state agencies. For instance, residents were labeled “difficult” and given special treatment (e.g. consistent assignment with a veteran CNA who had a smaller caseload) if their family members were more likely to report grievances. Meanwhile, individuals in the non-diverse nursing home lived and worked in an informal, collaborative, and non-confrontational environment, where they

did not experience the need for regulatory strategies because they had fewer complaints. This research highlights the need for effective WD strategies, and how the lack of diversity management can negatively influence other areas within the organization.

Mercer et al. (1993) interviewed 27 nursing home CNAs from Arkansas to better understand CNAs' perception of their salaries, in-service education, caseloads, and experiences with racial discrimination. The CNAs were female, mostly Black (85%), about 40 years old or younger, and living on a fixed income. The study revealed that the CNAs' salaries were not correlated with experience level, and many of the CNAs had to work extra shifts or multiple jobs to make ends meet. Only 25% of the CNAs believed their training prepared them to work in the nursing home and many believed they needed more resident-oriented training, such as how to manage and care for difficult residents. Additionally, the majority of the CNAs were dissatisfied with the number of residents they were assigned.

Regarding racism, 77.7% of the CNAs reported experiencing racism on the job (largely in the form of racial slurs), and even the CNAs who did not report being discriminated against, told personal stories of incidents involving racial slurs. Although the CNAs often overlooked these incidents because many of their residents were cognitively impaired, they reported feeling hurt and having diminished self-esteem after experiencing discrimination in the workplace. The CNAs also reported experiencing discrimination from their coworkers, supervisors, and the residents' family members. Reports of verbal and physical abuse were also common, with 92% of the CNAs having experienced some form of abuse from the residents. It was also common for reports of physical abuse to be racially charged. The authors concluded by highlighting the need for diversity training and more supportive supervisors who are in-tune to the experiences and needs of the CNAs.

In the workplace, when policies and procedures are handed down and strictly enforced, employees lose their sense of choice and/or influence. Karsten (2006) uses the term bureaucratic powerlessness to describe those individuals who attempt to maintain what little power they have through excessive control over their employees. Bureaucratic powerlessness is often present in nursing homes because nurses are in charge of the CNAs, but their orders are handed down from upper levels in the hierarchy (Foner, 1995). An ethnographic study designed to examine how racial and ethnic disparities influence the relationship among New York nursing home CNAs and residents revealed that nurses often delegated assignments to CNAs with little room for change without a nurse's approval. This constant need for approval caused CNA to exhibit aggravation, resentment, and hostility toward the nurses. The nurses' power and authority led CNAs to distance themselves from the nurses, which reinforced the nurses' status and increased their appearance of supremacy. The study also revealed that bonds between employees form, in part, along racial lines. For example, CNAs reported being more comfortable working with co-workers of the same ethnic group. The author concluded that the racial differences present in the nursing home reflect those within our society, stating, "racial differences feed into and intensify, rather than create, divisions between groups in the nursing home" (Foner, 1995, p. 149).

Another study by Berdes & Eckert (2001) used qualitative methods to explore race relations in nursing homes from the perspective of CNAs and residents. They interviewed 30 CNAs and 30 residents from three different nursing homes in Illinois. The authors found that racist language in nursing homes exists in two different forms: anachronistic and malignant racism. Anachronistic racism refers to the use of inappropriate, yet inoffensive language regarding race that was once deemed acceptable (e.g. colored or Negro), whereas malignant racism is blatant use of racist language that is meant to be offensive or disparaging (e.g. coon or

cracker). The majority of the residents, who were all White, indicated being aware of the racial disparities that existed in the nursing home, but did not perceive any racial problems in terms of the care they were provided.

Of the 30 CNAs interviewed, 1 was White, 15 were African American, and 14 were immigrants of Caribbean, African, or Asian descent. Similarly to the aforementioned study, over 70% of the CNAs reported experiencing racial discrimination from individuals in their work environment, and those who indicated they did not experience racism still described incidents of racism when responding to the interview questions. The CNAs reported incidents of racial discrimination were infrequent, despite the severity of the incidents. Some of the nurses took time to educate residents on the type of language that was currently socially acceptable. The foreign-born CNAs believed they were disproportionally affected by racism because they were also being discriminated against based on their accents and immigrant status. In the concluding statements, the authors argue that nursing home resident racial segregation facilitates anachronistic and malignant racism. They suggest that interventions focused on educating residents about culturally acceptable language and training staff to better understand dementia will help to improve race relations.

More recently, issues related to race in long-term care have come to the forefront in the media. A recent news article reported on a nursing home that was investigated by the New York State Attorney General after racial discrimination claims were made. The facility accommodated the preferences of a White resident who requested to only be cared for by White direct care workers. The nursing home also reassigned the African American staff members to other areas of the facility and they were not allowed to work on the hall or floor of this resident. Moreover, the statement “No Colored Nurses” was placed in the resident’s care plan (Mullaney, 2014). Further

investigation also revealed the nursing home did not have a formal anti-discrimination policy, there was no training provided on unacceptable conduct, and the employees were not educated on the New York Human, State, and Civil rights policies. In the settlement, reached in March 2014, the nursing home agreed to write and adopt a formal EEO policy, disseminate and display the policy for the employees, and appoint an EEO officer to enforce the policy and receive claims. The facility also agreed to hire an outside diversity consultant to conduct diversity training and provide comprehensive bi-annual reports regarding their anti-discrimination efforts to the Attorney General's office for three consecutive years (New York State Office of the Attorney General, 2014). Articles such as this paint a clear picture of the potential discriminatory acts occurring in nursing home facilities. This study highlights the strong need to address the racial discrimination that exists and put measures in place to protect employees from workplace racial discrimination.

The Author's previous research on nursing home workforce diversity. Vinson (2011) used qualitative methods to explore how nursing home leaders understand WD and how it is managed within a nursing home setting. The researcher conducted 11 interviews with 10 different leaders from a nursing home in Birmingham, AL. In the interviews, the leaders discussed their experiences, perspectives, and understanding of race, power, and WD. Using the grounded theory approach to data analysis, a model emerged to explain how the leaders enact WD in their organization. The Model of the Manifestation of Workforce Diversity (see Figure 1) illustrates how individual and organizational level factors influence how WD is carried out within the organization. Table 1 below provides relevant quotes from the nursing home leaders' to support the model.

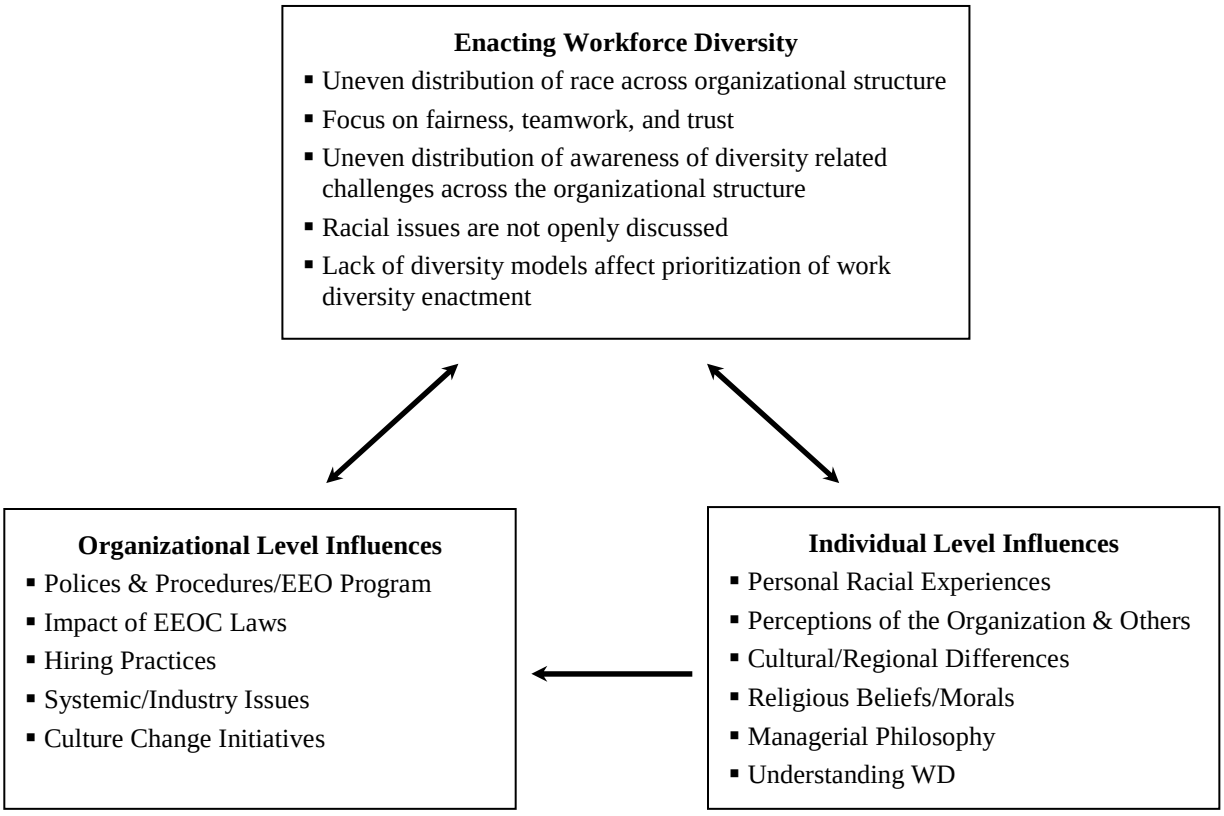

Figure 1. Model of the Manifestation of Workforce Diversity

Table 1

Nursing Leaders' Quotes to Support the Model of the Manifestation of Workforce Diversity

Theme	Quote
Individual Level Influences	**Personal Racial Experiences:** *I would never say that I know what it felt like to be [Black] in the 60s in Birmingham Alabama. I would never even begin to know that because I didn't experience it. But I heard the hate. And I experienced it from the perspective of being a White person, and I found it very, very distasteful as a child. I mean it, had a real significant impact on me.*
	Perceptions of the Organization & Others: *I would probably think [the staff] would perceive me very differently from the way I perceive myself […] They would probably perceive me as being inaccessible, not sensitive to their needs, they will probably perceive me as being distant.*
	Understanding WD: *You lead by modeling. You have to model what you expect other people to do. And being perceived as, as treating everyone the same way is, is a must. It's a critical component. […] Everything you do, you have to make sure that your modeling the appropriate behavior, down to how this office is staffed. We have to make sure that we are demonstrating a commitment to be a diverse culture.*
Organizational Level Influences	**Polices & Procedures/EEO Program:** *I don't know that we have—I'm trying to think about whether we have a written policy on diversity, per se. Now we have an equal employment opportunity policy, and that, so we don't have a policy, you wouldn't look in our manual and see diversity, you wouldn't see that, but you would see an EEO policy that says that it is our policy not to discriminate against anyone for any reason that's protected by law. Now we discriminate every day, legally in terms of who we pick and choose for jobs. But when I say, no discrimination, I mean, we're not—it is our policy not to discriminate because of race, religion, national origin, all of those things that are protected by law and, and that we, we are committed to that kind of policy. So, that's where the diversity comes from, I think is in compliance with the EEO policy.*
	Culture Change Initiatives: *The entire culture change movement is one that adopts diversity as one of its core values. And, that directly impacts minorities in management roles here by virtue of the fact that we'll, we'll be creating these households, and the people who know these resident best will be elevated into those positions of being responsible for those households. Well, who knows those people better than anyone? Well, it's the people who work with them every day. And who are those people? Well, the majority of them are Black females. So there will be dramatic opportunities for advancement. And I think that will—I think will go a long way in, in creating a more diverse management culture, or at least more diverse management picture diversity wise.*
Enacting Workforce Diversity	**A Focus on Fairness, Teamwork, & Trust:** *[Question: What are you're key concerns when managing diversity?] I think fairness. That everyone is treated the same—that's it more than anything. That whatever happens, if there is disciplinary actions or an appointment of a position that it doesn't weigh by color, that it weigh by ability. […] I think that goes back to the fact that for some reason people don't think people will respond to blacks the way that—older White Americans will not respond to Blacks the way they will to another White person in that position.*
	Uneven Distribution of Awareness of Diversity Related Challenges across the Organizational Structure: *There is no culture of race that I'm aware of that would cause an experience to be different for a White employee as opposed to a Black employee.* *I don't sense we have any wide-ranging issue of people feeling like there's a racial tension.*

Individual level influences. The individual influences referred to the leaders' personal experiences with and perceptions of race, cultural differences, power, and WD. The individual factors not only influenced how WD was enacted, but they also helped to shape the organizational culture of the nursing home. The participants' leadership style and role, as well as their morals and perceptions of the nursing home and its employees influenced how they managed diversity. All the leaders discussed their personal racial experience and the manner in which these experiences influenced how they approached their jobs. The leaders discussed how they believed others perceived them as well as perceptions of the organization. The focus of the discussions on the perceptions of the organization centered around the negative racial history of the facility. However, the leaders indicated through time, and a little extra effort from the leaders, they were able to effectively manage many of the negative perceptions. It became evident that regardless of the race of the leader, the lower level staff members felt as though they could not relate to their superiors, which created distance between the leaders and the staff members.

The nursing home leaders were also asked to provide their own definitions of WD and what their role was in managing diversity. Overall, there was a unanimous concentration on race or different ethnic backgrounds when the leaders defined WD. When discussing WD, the leaders voiced their opinions on their role in managing diversity and their key concerns when working with diverse groups. They all felt that managing diversity required that they treat everyone the same. In addition to trying treating everyone the same, others leader explained they also ensure everyone is patient with the foreign-born employees as they attempt to overcome language barriers, the employees are accepting of various cultures and traditions, and everyone is following the rules, especially when making hiring decisions.

Organizational level influences. The organizational level construct was defined as diversity related factors of the organizational culture that influence how WD manifests. Organizational factors influencing WD included systemic and industry norms, recent facility initiatives, and the impact of workplace discrimination laws. The nursing home's past and present hiring practices, and equal employment opportunity policies and procedures also had an effect on how diversity was managed within the facility. The study revealed the nursing home did not have formal diversity policies and procedures. When asked about diversity policies many people responded by discussing the EEO laws and guidelines, suggesting that the leaders consider these two concepts to be synonymous, which is consistent with previous research (Carrell et al., 2006).

Unfortunately, the organization once had a reputation for not being inclusive of minority workers, and the leaders once had a difficult time recruiting minorities to work at the facility. However, many of the leaders' descriptions of racial issues were expressed in terms of fairness and not race, and thus, were not protected under the law. Recently, the leaders tried to make intentional efforts to diversify the management team by promoting from within the nursing home and through various recruitment efforts in the community. However, as one participant explained, the leaders often fail to diversify because they recruit new employees from their own demographic networks. Furthermore, the leaders often found themselves in a hiring dilemma, in that they sometimes looked to replace former employees with people of the same racial group out of fear of being perceived as discriminatory. Thus, they missed out on opportunities to diversify the nursing home in other ways. When discussing hiring to diversify the organization, several leaders had strong and contrasting opinions as to whether race or national origin (i.e. English as a first language) should be taken into consideration when hiring new leaders.

Enacting workforce diversity. The manner in which leaders' enacted WD in the nursing home was the result of a combination of organizational and individual level influences. While issues of race were not openly discussed in this facility, WD in the nursing home manifested through a focus on fairness, teamwork, and trust. Consistent with previous literature, there was an uneven distribution of race across the organizational structure of the nursing home, as well as a lack of awareness of diversity related challenges in the highest tiers of leadership (Aries, 2004; Harrington, et al., 2000; Mercer et al., 1993; Singh et al., 2004). Furthermore, a lack of good models of WD influenced how it was prioritized within the facility.

Although the leaders' efforts were not necessarily attached to a specific diversity approach, their primary endeavors concerning WD centered around three major areas: fairness, teamwork, and trust. The leaders unanimously agreed that treating everyone equally was an important component of being a leader in the nursing home, and this undergirded several aspects of the individual and organizational level factors of the model. All of the leaders worked in diverse workgroups of some form, and they all tried to prevent diversity from getting in the way of being a team player and reaching the goals the group set out to achieve. Given the nursing home's racial history, the leaders felt that trust was important for thwarting any perceptions of racial discrimination. Unfortunately, developing trust was difficult in this environment because there were high rates of turnover and employees did not expect the leaders to have a prolonged tenure at the facility. As such, diversity also seems to be yet another reason to improve turnover in nursing home care.

The results of this study showed that the senior-level leaders were not always aware of the racial issues that took place in the facility and they tended to depict any such problems in a more favorable light. Although the researcher made an effort to have an open dialogue about race

in the nursing home, it was difficult to elicit responses about this subject, and it became evident that race was generally not a topic of discussion, especially at the corporate level. Instead, other terms, such as fairness were used as a proxy for race terms. Several leaders mentioned the problems with prejudice and discrimination that arose between various groups in the workforce were related to attitudes and personalities and had nothing to do with race. At other times, the leaders would say employees were not treated differently because of race, but would later discuss instances that were clearly discriminatory. The leaders believed the resolution to the racial problems was *"to recognize that it exists and to try to deal with it the best way we can."* However, this was difficult when the facility as a whole did not talk about the racial issues. The leaders' level of comfort with these discussions seemed to be a barrier. One possible explanation is that leaders fear discussing or admitting to discriminatory behaviors and decisions will lead to designations of racism or illegal activity. Thus, these actions might lead to negative judgments toward the person instead of simply behaviors to be modified.

Overall, this study suggests there is an important need for interventions to help nursing homes improve WD. Other implications for improving diversity management include developing a better understanding for how WD is defined. As more consideration is given to diversity management, it will become imperative for organizations to distinguish between EEOC laws and formal WD management strategies. Furthermore, although diversity management is likely to counteract EEO claims, EEO policies will not address the underlying causes of any prejudice and discrimination that exists, nor will they help diverse groups to feel valued for their different perspectives.

Nursing Home Characteristics

National. Today 1.38 million individuals reside in nursing homes. Sixty-eight percent of the15,622 facilities in the U.S. are for-profit facilities, while 26% are non-profit and 6% government-owned. The national occupancy rate is 83.3%. Medicaid covers the majority of nursing home residents (63%), and Medicaid and private-pay insurance covers 14% and 22% of residents respectively; 95% of residents are dually certified for Medicare and Medicaid. Each resident receives a total of 3.9 hours of nursing care per day, with 1.5 of these hours coming from a licensed nurse. Nearly 94% of nursing homes have deficiencies, with approximately 9.4 deficiencies per facility. The top five deficiencies in nursing homes include infection control (43%), accident environment (43%), food sanitation (39%), quality of care (34%), and profession standards (30%; Kaiser Family Foundation, 2010).

Table 2 compares the national and statewide totals for nursing assistants, licensed practical nurses (LPN), registered nurses (RNs), and medical/health service managers employed and their wages. Table 3 provides the racial composition of the workforce, which can be compared to the racial composition in each state and nationwide (See Table 4). It is important to note that percentage of African American medical/health service managers appears to be comparable to the total percentage of African Americans in the U.S.; however, this figure also includes mid-level management positions such as director of nursing, food service director, clinical care coordinator, and unit manager.

Table 2

National and State Total CNA, LPN, RN, and Medical/Health Service Manager Workforce

	Certified Nursing Assistant		Licensed Practical Nurse		Registered Nurse		Medical/Health Service Manager	
Location	#	Mean Hourly Wage	#	Mean Hourly Wage	#	Mean Hourly Wage	#	Mean Hourly Wage
AL	14,240	$10.38	14,290	$16.56	45,400	$27.81	2,140	$42.47
GA	24,040	$17.59	24,040	$17.59	65,240	$29.98	9,650	$41.35
MS	10,620	$16.62	10,620	$16.62	29,640	$28.59	2,390	$37.38
TN	22,650	$17.38	22,650	$17.38	60,570	$29.16	7,100	$40.50
National	627,370	$11.76	215,270	$20.72	138,080	$29.25	20,090	$38.82

Note. National data only includes individuals employed in nursing care facilities, while the state data includes the total state workforce for each occupation regardless of facility type (Bureau of Labor Statistic, May, 2011).

Table 3

Total CNA, LPN, RN, and Medical/Health Service Manager Workforce by Race

Race	Certified Nursing Assistant	Licensed Practical Nurse	Registered Nurse	Medical/Health Service Manager
White	58.6%	69.3%	78.6%	83.4%
Black/African American	34.6%	24.4%	12%	12.4%
Asian	4.0%	3.8%	7.5%	3.2%
Hispanic/Latino	14.7%	6.2%	4.9%	7.2%
Total (In thousands)	1,928	573	2,843	549

Note. Total indicates the total number of individuals in the workforce for each occupation regardless of facility type (Bureau of Labor Statistic, August, 2011).

Table 4

Total Population by Race

Race	National	Alabama	Georgia	Mississippi	Tennessee
White	72.4%	68.5%	59.7%	59.1%	77.6%
Black/African American	12.6%	26.2%	30.5%	37.0%	16.7%
Asian	4.8%	1.1%	3.2%	0.9%	1.4%
Hispanic/Latino	15.4%	3.7%	8.2%	2.5%	4.3%
Total (In thousands)	308,746	4,780	9,688	2,967	549

Note. (U.S. Census Bureau, 2010).

Training in nursing homes is usually done in the form of new employee orientation or an in-service. Currently, with the exception of emergency and disaster procedures, topics included in orientation are at the discretion of each individual nursing home, and few states require specific topics be covered beyond the federal requirements. Federal regulations only require in-service training for CNAs. The content of the in-services is determined by the facility, but must include cognitive impairment if the CNAs interact with individuals with dementia (NH Regulations Plus, 2011). Table 5 shows the nursing home facility characteristics for the four target states and the national averages.

Table 5

Nursing Home Facility Characteristics

Characteristic	AL	GA	MS	TN	National
Facilities	228	357	204	322	15,622
Residents	22,920	32,286	16,367	32,060	1,385,251
For-profit	79%	63%	63%	74%	68%
Non-profit	14%	31%	9%	19%	26%
Occupancy Rate	86%	86%	88%	86%	83%
Dual Eligibles	98%	98%	85%	93%	95%
Hours of Care	4.3	3.7	4.0	3.8	3.9
Number of Deficiencies	6.1	5.3	6.8	6.6	9.4
Top Deficiencies	FS, IC, AE	QC, IC, AE	IC, PS, FS,	IC, AE, QC	IC, AE, FS
Additional Training Requirements	No	Yes	Yes	No	--

Note. IC: Infection Control, AE: Accident Environment, FS: Food Sanitation, QC: Quality of Care, PS: Professional Standards; (NH Regulations Plus, 2011).

Alabama. There are currently 228 nursing homes in the state of Alabama serving 22,920 residents. Of the four states being sampled, Alabama has the highest number of for-profit nursing homes (79%), while 14% are non-profit and 6% government-owned. The Alabama occupancy rate (86%) is slightly above national averages. Medicaid covers 68% of all Alabama nursing home residents, Medicare covers 14%, and private insurance covers 19% of Alabama nursing home residents; however, 98% of all nursing home beds are dually certified. Each resident receives approximately 4.3 hours of care from nursing staff each day, with 1.6 hours being from licensed staff members. The percentage of facilities with deficiencies is 90.4%, and homes average 6.1 deficiencies per facility. Alabama has more nursing home with deficiencies in food sanitation (43%) than infection control (40%), accident environment (25%), quality of care (8%), and professional standards (23%; Kaiser Family Foundation, 2010). In terms of state regulations, Alabama requires a certificate of need, which means facilities can only build, expand, or acquire new facilities if there is a need for such within the community (National Conference of State Legislatures, 2011). In terms of nursing home training, Alabama does not go beyond the federal regulations for CNA requirements for orientation and in-services (NH Regulations Plus, 2011).

Georgia. Georgia has 357 nursing homes and 32,286 nursing home residents with an 86.4 occupancy rate. The profit status for nursing homes in Georgia is 63% for-profit, 31% non-profit, and 5% government-owned. Currently, 72% of residents use Medicaid as their primary payer source; an additional 13% use Medicare and 15% use private insurance to cover their long-term care costs. Dual eligibles account for 97.5% of Georgia nursing home residents. Licensed nurses provide about 1.5 hours of care to each resident per day, and Georgia is below the national average for total hours of care per day (3.7). In Georgia, 86.6% of nursing homes have at least one deficiency, and most nursing homes have an average of 5.3 deficiencies. Although

Georgia nursing homes have fewer deficiencies overall, the state's nursing homes have the highest deficiencies in quality of care (39%), infection control (28%), accident environment (25%), food sanitation (22%), and housekeeping (21%; Kaiser Family Foundation, 2010). Georgia is a certificate of need law state. Georgia does not does not go beyond federal requirements for new employee orientation. However, the state does require that all nursing homes have an active in-service program coordinated and taught by a registered nurse. They also require nursing staff have training from a social worker on how to address resident's emotional problems and social needs (NH Regulations Plus, 2011).

Mississippi. There are 16,367 individuals who reside in one of 204 Mississippi nursing homes. Sixty-three percent of the Mississippi nursing homes are for-profit facilities, while 9% are non-profit and 14% government-owned. Mississippi has the highest occupancy rate (88.4%) among the four states. Medicaid covers the majority of nursing home residents (75%), and Medicaid and private-pay insurance covers 15% and 10% of residents respectively; 85.3% of residents are dually certified for Medicare and Medicaid. Each Mississippi resident receives four hours of nursing care per day, with 1.6 of these hours coming from a licensed nurse. Only 2.5% of Mississippi's nursing homes are completely free of deficiencies, and most of the state's nursing homes have approximately 6.8 deficiencies per facility. The top five deficiencies in Mississippi nursing homes include infection control (51%), professional standards (46%), food sanitation (39%), clinical records (38%), and comprehensive care plans (30%; Kaiser Family Foundation, 2010). Mississippi law requires a certificate of need. The only added addition to Mississippi's state regulations is a requirement for a written record of orientation and in-service training for each employee.

Tennessee. Tennessee has 322 nursing homes and 32,060 nursing home residents with a 85.7% occupancy rate. The profit status for nursing homes in Tennessee is 74% for-profit, 19% non-profit, and 5% government-owned. Currently, 63% of residents use Medicaid as their primary payer source; an additional 16% use Medicare and 22% use private insurance to cover their long-term care costs. Dual eligibles account for 93.4.5% of Tennessee nursing home residents. Licensed nurse provide about 1.6 hours of care to each resident per day, and each resident receives a total of 3.8 hours of care per day. In Tennessee, 93.4% of nursing homes have at least one deficiency, and most nursing homes have an average of 6.6 deficiencies. Although Tennessee nursing homes have fewer deficiencies, nursing homes have the highest deficiencies in infection control (56%), accident environment (36%), quality of care (33%), clinical records (27%), and professional standards (25%; Kaiser Family Foundation, 2010). The state of Tennessee requires a certificate of need. Tennessee does not go beyond the federal regulations for employee requirements for orientation and in-services (NH Regulations Plus, 2011).

CHAPTER 3

METHODOLOGY

The following section details the study methodology, which consists of the study design, recruitment, survey measures, study procedures, data analysis, and modifications to the proposed methods.

Study Design

Survey methodology was employed for this study. A structured questionnaire was developed with questions generated from a review of the business and healthcare literature. The survey was piloted with two leaders from the Tuscaloosa Veterans Affairs Medical Center (TVAMC) Community Living Center to determine the appropriateness of the survey questions, length, and to suggest additional questions/topics to include in the survey. The survey was divided into four sections: research consent, demographics, organizational characteristics, and diversity and its management. The final questionnaire included 39 questions that took approximately 15 minutes to complete (See Appendix A for survey items). Additional information on nursing home internal and external factors was collected from the following websites: Nursing Home Compare, U.S. Census Bureau FactFinder, and WWAMI (Washington Wyoming, Alaska, Montana, and Idaho) Rural Health Research Center (https://data.medicare.gov/data/nursing-home-compare; http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml; http://depts.washington.edu/uwruca/index.php). The dependent variable for this study was diversity management practices, and it was used to address specific aims three and four. Nursing

home internal (i.e. profit status, chain affiliation, and Medicaid census, culture change adoption, and workforce racial composition) and external (i.e. geographic location and community racial composition) factors served as independent variables.

Sample and Sampling

A leader was defined as either a nursing home administrator, assistant administrator, or director of nursing (DON), as these individuals are members of the facilities' governing body and their attitudes about and efforts regarding workplace diversity management are most likely to have an organization-wide effect. Participants were sampled from nursing homes in four states in the Deep South: Alabama, Georgia, Mississippi, and Tennessee. According to the Nursing Home Compare website of U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services (2012; http://www.medicare.gov/NHCompare), there were 228 facilities in Alabama, 357 in Georgia, 204 in Mississippi, and 322 in Tennessee at the initiation of this study. Eligible participants for the study were employed at a Medicare and Medicaid-certified nursing home in the four target states. All 1,111 facilities were invited to participate in the survey.

A power analysis indicated that a total of 277 nursing home leaders were needed for the study. However, the desired sample size was not achieved due to the difficulties with data collection (see Modifications to Proposed Methods below on page 67). The survey completion characteristics are included in Table 6 below. A total of 180 individuals initiated the survey. There were 152 individual who completed at least 50% of the survey, and 97 of these individuals completed the full survey. There were 71 leaders who declined to participate in the study. Fourteen of the 180 individuals declined to participate after initiating they survey (5 individuals marked "I do not agree," 5 individuals stopped after Item 1, 4 individuals indicated their facility

was out of operation/not providing nursing home services); 62 individuals declined by phone. The four facilities that were determined to either be out of operation or no longer providing nursing home services were removed from subsequent analyses. Thus, the final dataset included 1107 total nursing homes across in the dataset four states.

Table 6

Survey Completion Characteristics

Survey Completion *N* (%)	AL	GA	MS	TN	Total
Survey method					
Paper	22 (44.9%)	13 (27.1%)	15 (57.7%)	26 (45.6%)	76 (42.2%)
Online	27 (55.1%)	35 (72.9%)	11 (42.3%)	31 (54.4%)	104 (57.8)
Participation					
Agreed	47 (73.4%)	40 (59.7%)	25 (64.1%)	54 (75.0%)	166 (68.6%)
Declined by survey[a]	2 (3.1%)	8 (11.9%)	1 (2.6%)	3 (4.2%)	14 (5.8%)
Declined by phone	15 (23.4%)	19 (28.4%)	13 (33.3%)	15 (20.8%)	62 (25.6%)
Survey completion					
Full	28 (12.3%)	24 (6.7%)	9 (4.5%)	36 (11.2%)	97 (8.8%)
Partial (≥ 50%)	14 (6.1%)	12 (3.4%)	16 (7.9%)	13 (4.0%)	55 (5.0%)
Partial (≤ 50%)	5 (2.2%)	4 (1.1%)	--	5 (1.6%)	14 (1.3%)
Non-respondents	181 (79.4%)	316 (88.8%)	177 (87.6%)	267 (83.2%)	941 (85.0%)
Response rate[b]	18.4%	10.1%	12.4%	15.3%	13.7%

Note. [a] Includes individuals who marked "I do not agree" to participate in the study, Facilities not in operation or not offering nursing home services, as well as those who initiated the online survey, but stopped after Item 1.
[b] Response rate calculated using all participants completing at least 50% or more of the survey items.

Measures

Workforce diversity knowledge and attitudes. The first aim of the study was to examine how nursing home leaders understand and characterize WD. Diversity knowledge was

measured by two relevant questions derived from Carrell and Mann's (1993) questionnaire developed to assess organizational decision makers' understanding of WD (See items 24 and 36 in Appendix A; Carrell & Mann, 1993; Carrell et al., 2006). Item 24 measured the leaders' perceptions of the components of diversity, which included a list of diversity characteristics and asked participants to indicate which characteristics they believe were included in the term diversity. Two additional characteristics that were not included in the aforementioned studies (education and income) were added to the item based on comments from piloting the survey. The terms culture, race, age, gender, and national origin were considered primary characteristics, as they are included in EEO/AA definitions. The remaining terms (religion, language, handicap/physical, regional/geographic location, sexual orientation, education, and income) were categorized as secondary characteristics. Item 36 examined the meaning of diversity by asking participants to indicate whether WD is substantially different from EEO/AA programs. The responses for these two items could either be "yes," "no," or "uncertain."

Diversity attitudes and perceptions were assessed with the Reaction-to-Diversity (R-T-D) Inventory developed by De Meuse and Hostager (2001; Appendix A, item 23). The measure was designed as a quantifiable measure of an individual's positive and negative attitudes and perceptions toward WD along five dimensions:

1. Emotional reactions – initial, visceral responses to workplace diversity; an individual's "gut feelings" about diversity in general;
2. Behavioral reactions – what an individual does (or intends to do) in response to diversity; verbal and nonverbal actions;
3. Judgments – an individual's normative evaluation of diversity; one's value judgments regarding diversity in principle (e.g., is diversity good or bad);

4. Personal consequences – beliefs regarding perceived outcomes on an individual level; an individual's views on how diversity will affect them personally; and
5. Organizational outcomes – beliefs regarding perceived outcomes on an organizational level; an individual's views on how diversity will affect the company as a whole (De Meuse & Hostager, 2001, p. 37).

The R-D-T has been used in several studies, (De Meuse, Hostager, & O'Neill, 2007; Hostager & De Meuse, 2002, 2008; Thomas, 2008), and has acceptable internal consistency, with a Cronbach's Alpha coefficient of .78 (Brouwer & Boroş 2010). The measure consisted of a random list of 70 words associated with the positive and negative dimensions, in which participants were required to select the words they frequently associated with diversity. Each positive word selected received a score of +1, whereas negative words received a -1. The scores ranged from -35 to +35, and the dimensional subscores ranged from -7 to +7. The descriptive characteristics were diversity pessimist/negative, realist/neutral, and optimist/positive (scores ranging from -35 to -11, -10 to +10, and +11 to +35 respectively). Higher scores indicated more positive attitudes and reactions toward diversity, whereas lower scores indicated the reverse.

Diversity management. Diversity management was assessed through a series of questions related to diversity policies, programs, and perceptions of diversity management. Items 37-39 list examples of specific diversity management practices and initiators of diversity management (specific aim two), including activities associated with diversity (Item 37), the sources of diversity (Item 38), and written policies or programs that include the concept of diversity (Item 39). These items were selected from the aforementioned longitudinal study of organizational decision makers' understanding of WD (Carrell & Mann, 1993; Carrell et al.,

2006). For item 37, the additional response option, *communication/interpersonal skills*, was added given that CMS requires CNAs to be trained in this topic area. Furthermore, skills enhancement was changed to skills enhancement/in-service education because in-service education is the terminology most often used for skills enhancement in nursing home settings. Additional response options (*mid-level managers/supervisors, RNs/LPNs, and CNAs*) were also added to item 38 to reflect the possible sources that could potentially initiate diversity policies, programs, and discussions in a nursing home setting.

Based on research from case studies on healthcare and corporate organization's best practices in diversity leadership, Dreachslin (1996, 1999) developed a five-part framework for diversity leaders interested in organizational change: discovery, assessment, exploration, transformation, and revitalization. The discovery stage involves developing awareness of the importance of diversity as a strategic management matter. Assessment entails conducting a structured evaluation of the climate and culture of the organization in relation to diversity issues. Exploration is conceptualized as formal diversity training strategies conducted to implement effective diversity management across the organization. The transformation stage converts organizational systems, which brings about complete organizational climate and culture change where leaders and employees value diversity. Revitalization refers to the regeneration and evolution of diversity initiatives to incentivize individuals who are catalysts for change and to gradually increase the types of diversity groups the organization includes in their initiatives.

The framework of diversity leadership stages proposed a total of 82 performance indicators, which identified specific actions that organizations operating under a particular stage would likely engage in; the indicators were designed to serve as a self-assessment tool to help organizations identify their diversity management orientation or stance. Organizations engaging

in diversity management activities within the later stages are thought to be multicultural and successfully managing WD. Such organizations also have high performance in the prior stages. Weech-Maldonado and colleagues (2002) used the framework and performance indicators to develop a survey to assess diversity management in Pennsylvania hospitals. The survey included 54 of the performance indicators developed by Dreachslin (1999); two items did not appear to be derived from the earlier framework. The responses for each diversity management activity were measured using a 5-point Likert scale (ranging from 5 = strongly agree to 1 = strongly disagree). Using factor analysis, the authors categorized the 54 indicators into 6 diversity performance subscales (planning, 8 indicators; stakeholder satisfaction, 6 indicators; diversity training, 15 indicators; human resources, 11 indicators; healthcare delivery, 8 indicators; and organizational change, 6 indicators) that corresponded to Dreachslin's (1996, 1999) five-part framework of diversity leadership stages previously described above. The six subscales had strong reliability, and the lowest Cronbach's Alpha was .80 (healthcare delivery) while the highest was .94 (diversity training). As previously suggested, the study revealed that hospitals were more likely to report engaging in planning and evaluation diversity training activities and less likely to engage in human resource and organization change performance indicators. Another study developed a 64-item survey using the same performance indicators to assess the relationship between diversity management and sensitivity to diversity. This measure also had strong internal consistency, with a Cronbach's Alpha of .96 (Dansky et al., 2003).

The availability of brief, comprehensive diversity management scales are limited. Furthermore, very few studies are normed on leadership or management populations, and many do not report the psychometric properties of the measures used in studies. For example, Leveson and Joiner (2009) developed a 10-item cultural diversity management perceptions scale to

examine the relationship between cultural diversity management, perceived organizational support, and affective commitment. Although, this measure did report adequate internal consistency, it was only used in one study and it was developed to assess employees in non-managerial/leadership positions. Additionally, it only measured two aspects of diversity management – perceived organizational support and access to formal networks.

Given the limitations of the available diversity management scales, the diversity management assessment solution for the current study was to use the performance indicators from the five diversity performance subscales (i.e. planning, stakeholder satisfaction, diversity training, human resources, healthcare delivery, and organizational change) by Weech-Maldonado et al. (2002) such that the current scale would only include a small number of indicators germane to nursing homes. The 10-item diversity management scale (See Appendix A items 25-34) developed for this study contains selected applicable indicators from each of the five aforementioned diversity performance subscales in the Weech-Maldonado et al. (2002) study. This scale was used to address specific aims three and four.

Only one indicator from the healthcare delivery subscale was included (item 33 *"Management talks openly about issues of race/ethnicity"*) because diversity management related to patient/resident healthcare, satisfaction, and outcomes are outside of the scope of the current research. Furthermore, other non-workforce related indicators focusing on the community or patient/resident healthcare were also excluded. When the subscales contained multiple indicators pertaining to the same concepts, only one was used. For example, the following planning indicator pertaining to an organization reflecting its service area was included in the current scale: *"The demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area"* while a similar planning indicator was not used

in the current scale (e.g. *"Information about the services area's current and projected racial/ethnic demographics is routinely gathered."*). Additionally, some items were combined to form a single item in the current scale. For instance, indicator 5 from the planning subscale and indictor 4 from the human resources subscale were combined to create item 25 on the current survey. Survey item 26 was created by combining planning subscale indicator 8 with human resources indicator 8. Finally, indictors 3, 5, 6, 7, 10, and 13 from the diversity training subscale were combined to create survey item 29 (See Appendix A for each of these items). In the Weech-Maldonado et al. (2002) article, the authors indicated the percentage of senior management leaders who reported engaging in each of the diversity management activities. Items reported to have the lowest percentage of hospitals currently engaging in the activity were excluded. For example, only 2.9% hospital leaders in the previous study endorsed organizational change subscale indicator 6: *"Change agents who spearheaded the first racial/ethnic diversity initiatives in our organization have been promoted in part as a result of their efforts."* Given the similarities in leadership and organizational structure between hospitals and nursing homes, it is likely that nursing home leaders' responses to these items would be similar. The responses for each item in the current diversity management scale were measured using the same 5-point Likert scale (5 = strongly agree, 4 = agree, 3 = neither agree nor disagree, 2 = disagree, and 1 = strongly disagree) from the Weech-Maldonado et al. (2002) study. The scores for each item were summed and then averaged to get a total mean diversity management total score (ranging from 1 to 5), and higher scores indicated an increase in diversity management practices.

Internal factors. The third aim of the study was to examine how organizational and internal factors such as profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition influence WD management practices. Two of the internal

factors included in the study (profit status: for-profit vs. non-profit and chain affiliation: independent vs. chain affiliated) were collected from the Nursing Home Compare website (CMS. 2012). Medicaid/Medicare census information is not available through this website, thus, participants were asked to provide their census information (categories of percentages; 0-20%, 21-40%, 41-60%, 61-80%, and 81-100%) on the survey (Appendix A items 11-12). Items 14-16 assessed facility racial composition, including the administrator and director of nursing, the nursing and managerial staff, and the residents. For items 15 and 14 that leader was asked to identify the number of staff members or residents that fall into each racial group.

Culture Change adoption was assessed using items adapted from the Artifacts of Culture Change Tool, which was developed by the Centers for Medicare and Medicaid Services (CMS) and members of the Pioneer Network, an organization that serves as a clearinghouse for the culture change movement. The purpose of the tool is to assess the changes in nursing home climate, attitudes, policies, procedures, and resident care practices that reflect adoption of culture change. The tool has 79 items and measures culture change adoption in six areas: care practices, environment, family and community, leadership, workplace practice, and staffing outcomes and occupancy. One item was chosen from each of the major artifact sections (Appendix A items 17-22). The items selected for this survey were thought to be the most commonly cited in the culture change literature and did not require substantial resources or changes to the physical environment because the availability of financial resources may limit such changes (Bowman & Schoeneman, 2006; Frampton et al., 2010). For items 17, 19, 20, and 21, the respondents indicated whether the particular item describes practices/procedures in their facility always, often, sometimes, occasionally, or never. The item score ranged from 1 (Never) to 5 (Always). Item 18 assessed the percentage of residents living in environments that were indicative of

culture change. Scores for this item were reversed so that higher percentages are scored higher (0% = 1; 1-20% = 2; 21-40% = 3; 41-60% = 4; 61-80% = 5; 81-10% = 5). For item 22, respondents were required to select the percentage range indicative of their facility's current turnover rate. The scoring for this item ranged from 1 (100%) to 5 (0-19%) and responses marked 80-99% and 100%+ were both be scored as 1. The scores for each item were summed and averaged to get a total culture change adoption score (ranging from 1 to 6), and higher scores indicated an increase adoption of culture change principles and practices.

External factors. External Factors also served as predictor variables to address aim four. Data from the 2010 U.S. Census was used to measure the community racial composition, which was determined by calculating the percentage of Whites living within the zip code of the facility relative to all community members within that same zip code. The percentage ranged from 0-100%, and higher percentages indicated less community racial diversity. If the facility's current zip code did not exist prior to the 2010 Census data collection, the community racial composition variable could not be computed. There were 20 facilities across the four states that had missing data for community racial composition. The zip code for each participant's facility was also used to determine the urban/rural geographic location for each site. Urban/rural classification was defined using the 2000 Rural Urban Commuting Area (RUCA) codes, which were classified into four categories: urban focused, large rural city/town (micropolitan) focused, small rural town focused, and isolated small rural town focused (RUCA Rural Health Research Center, n.d.).

Demographic variables. The demographic variables collected in the survey included the following: age, gender, race/ethnicity of participant, citizenship, years employed, years in current position, years working in long-term care, years working at current nursing home, and education/training (Appendix A items 1-10).

Additional items. Given the research on the nursing home immigrant workforce and racial discrimination, two additional exploratory items were added to the questionnaire (Appendix A items 13 and 35). The rise in immigrant residents has increased the need for translation services in the form or bilingual employees, medical translators, and/or language banks. Thus, item 13 asked whether these services are readily available in the facility. Furthermore, as previously stated above, native and foreign-born minorities are more likely to report being racially discriminated against on the job; however, these studies have mostly surveyed direct-care workers. Accordingly, item 35 asks the nursing home leaders if they have ever been discriminated against because of their race or ethnic origin.

Procedures

A random number generator was used to assign each nursing home a unique identification number (ID#) that was preceded by the first letter of the state the nursing home was located in; there was a separate list for each state. For example, the identifications numbers for Alabama ranged from A001 to A228 and the numbers from Georgia will range from G001 to G357. Approximately half of the nursing homes in each state were contacted, and an attempt was made to speak with the administrator of the nursing to inform him/her about the survey and obtain a reliable mailing and email address to send the survey and any additional follow-up (See Appendix B for the telephone script). These individuals were contacted by phone up to five times over the course of the data collection period, as previous studies indicate that responses are more likely if personal contact has been made. On the fourth and fifth calls if the administrator was not available, the caller attempted to speak with the Director of nursing (DON) or assistant administrator. On the final call, if the administrator, assistant administrator, or DON were not available, the facility administrator's name, email, and mailing address were obtained from

whoever was readily available to provide this information. If no contact was made on the fifth attempt, the survey packet was mailed to the facility.

Survey mail-out procedures included the following: 1) Individuals who requested to complete the pen/paper survey received a packet that included an introductory letter re-introducing the study, informed consent form, a paper survey, and a stamped return envelope; 2) Individuals who requested to complete the online version of the survey received an email that included the introductory letter re-introducing the study and a link to the online survey, which included a copy of the informed consent form (See Appendix C and D for introduction letter and consent form). The email addresses for nursing home administrators in AL and GA were readily available through online directories (Alabama Nursing Home Association, n.d.; Georgia Health Care Association, 2013). Each administrator with a valid email address in the directory was also emailed the introduction letter with the link to the survey and informed consent document. During the last two months of the data collection period, a follow-up email reminder was sent out to the individuals that agreed to complete the survey, but had yet to do so.

Data Analysis

Descriptive analyses were conducted for each demographic item (Items 1-10). To compare individuals completing at least 50% of the survey to non-participants, t-tests were performed for the continuous variables (community racial composition, number of residents, bed size, and occupancy rate), and Chi-square tests for independence were performed for the categorical variables (profit status, chain affiliation, and geographic location). Descriptive analyses were also conducted for the two exploratory items: availability of translation services and experiences with racial discrimination, which are both categorical variables.

The first aim of the study was a descriptive aim. Descriptive analyses were conducted to develop the summary scores, frequencies, means, and chi-square comparisons necessary to examine how leaders understand and characterize WD. The second descriptive aim was to explore the specific diversity management practices currently being implemented in nursing home facilities. As above, descriptive analyses were conducted to develop the summary scores, frequencies, means, and chi-square comparisons necessary to investigate this aim.

Aims three and four were predictive aims that examined how internal and external factors influenced WD management practices. These aims were addressed using multiple regression analyses. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homoscedasticity, and multicollinearity (Pallant, 2007; Stevens, 2002). Before conducting the regression analyses, the univariate correlations of the demographic variables with the diversity management practice scores were examined to determine if any demographic variables needed to be entered as covariates in the subsequent regression analyses. The results revealed that none of the demographic variables needed to be used as covariates in the regressions. Finally there has been no previous literature using the present diversity management scale as a predictor. Thus, standard multiple regression was used instead of hierarchical multiple regression, and all of the independent variables were entered into the equation at once (Cohen, Cohen, West, & Aiken, 2003).

The first regression analysis addressed aim three, and it examined how well internal factors predicted WD management practices. The dependent variable for this regression analysis was the WD management practices score, which was calculated as the average of survey items 25-34. The internal factors (profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition) served as the dependent variables for this regression

analysis. Workforce racial composition was derived by calculating the percentage of Whites out of the total number of people in the facility.

The second regression analysis was used address aim four, and it examined how well external factors predicted WD management practices. The WD management practices score again served as the dependent variable, and the external factors (community racial composition and geographic location) were the independent variables. Community racial composition was derived by calculating the percentage of Whites out of the total number of people in the community.

Modifications to Proposed Methods

This section describes changes made to the proposed methods to address unanticipated challenges; each change was previously discussed with, and approved by, the dissertation co-chairs, and reported to the committee via email updates.

Given the large number of nursing homes sampled (1,111 across 4 states), it was proposed that the data would be collected in waves over a 13-week period, where half of the facilities would be contacted by phone prior to sending out the survey. In the initial study design, 48 facilities (ID#s 1-12 from each state) were to be called during the first week. During week two, 48 new facilities (ID#s 13-25 from each state) were to be called and surveys were to be mailed, or e-mail if requested by the participant, to 96 facilities (48 to facilities call the previous week and 48 to facilities that were not called). The same calling/mailing scheme was to continue through week 12, and the final surveys were to be mailed during week 13.

Data collection began in Fall 2012, and research assistants were recruited to assist in data collection. Coordinating schedules to make the initial telephone calls among the author and research assistants proved to be difficult, as such, a decision was made to move forward with

preparing and mailing out the 556 surveys to the facilities that would not be called prior to sending out the survey. There were 56 surveys returned, and of the 56 surveys, five leaders checked the box indicating they did not agree to participate in the study. One of the nursing homes facilities was found to be out of operation subsequent to the survey being mailed and was removed from the study (and not counted in the response rate).

The phone calls to the remainder of the facilities were made February 2013 through February 2014 by the author and three research assistants, as their schedules permitted. In addition to scheduling difficulties, there were also unanticipated barriers to making contact with the leaders including, lengthy call waiting times, the receptionists' or "gatekeepers'" willingness transfer the call, limited leader availability due to "State Survey" season and/or conference attendance, and finding the optimal time to reach the leader (i.e. before business hours, during or right after lunch, etc.). The outcomes from the call procedures are listed in Table 7 (below). There were a total of 1,628 calls made to nursing homes across the 555 facilities in the four states. Sixty-one individuals declined to participate in the survey, and three facilities (two in MS and one in GA) were removed from the study after the leaders indicated their facilities were no longer providing long-term care services. Forty of the 59 GA facilities that did not receive of paper copy of the survey had valid email address in the online directory, and were subsequently sent an online version of the survey.

Table 7

Data Collection Calling Procedure Outcomes

Condition *N* (%)	AL	GA	MS	TN	Total
Agreed to participate by phone	71(62.3%)	89 (49.4%)	69 (67.6%)	102 (64.2%)	331 (59.6%)
Declined to participate by phone	15 (13.2%)	19 (10.6%)	13 (12.7%)	15 (9.4%)	62 (11.2%)
Survey mailed after 5th phone attempt	14 (12.3%)	13 (7.2%)	10 (9.8%)	30 (18.9%)	67 (12.1%)
Paper survey mailed prior to 5th phone attempt	14 (12.3%)	--	11 (10.8%)	12 (7.5%)	36 (6.5%)
Paper survey was not mailed (1-4 phone attempts made)	--	59 (32.8%)	--	--	59 (10.6%)
Total Response rate [a]	114 18.4%	180 10.1%	102 12.4%	159 15.3%	555 13.7%

Note. [a] Response rate calculated using all participants completing at least 50% or more of the survey items.

At the end of year one, a total of 460 leaders had been contacted and either accepted or decline the invitation to participate in the study, and at least one attempt had been made to contact the remaining 95 facilities by telephone. Given the overall low response rate and lengthiness the data collection process, a decision was made by the author and committee members to conclude the data collection process and proceed with the analyses despite not reaching the desired sample size of 277. However, in a final attempt to increase the sample size, paper surveys were mailed to the remaining 36 facilities that had yet to be contacted in AL, MS, and TN. Paper surveys were not mailed to GA, as leaders from these facilities were previously contacted by email using the online directory described above.

It was also anticipated that the response rate for each state would reach 25%, and the data collection procedures described above would be used to ensure that each state is equally represented in analysis. The difficulties in data collection described above, did not allow for the author to obtain a similar response across all four states. The response rates per state are listed above in in Table 7. The response rate of the total sample was 13.7%; Alabama had the highest

response rate and Georgia had the lowest (18.4% and 10.1%, respectively). It is possible that the response rate for GA was lowest because this was the only state where each facility did not receive a paper copy of the survey, and research suggests paper surveys yield the highest response rate when more than one method is used (Dillman, Smyth, & Christian, 2009). The response rates in the literature referenced for this study ranged from 17-80%, and literature on conducting survey data suggests that a 30% response rate is typical for survey data (Kaplowitz, Hadlock, & Levine, 2004; Sheehan, 2001).

Finally, a qualitative thematic analysis was proposed for the open-ended questions on differentiating WD from EEO/AA programs and how a facility's written diversity policy was different from EEO/AA programs (Items 36 and 39) to identify qualitative themes or patterns in the data. However, very few leaders answered these items in the survey (18 respondents for item 36; 11 respondents for item 39), and several leaders provided simplistic responses. Given the small response rate for these items it would be difficult to identify themes across the respondents or generalize the responses across the nursing homes in the sample. Therefore, instead of conducting the thematic analysis, a selection of quotes was identified, and they are reported in the results.

CHAPTER 4

RESULTS

Sample Characteristics

A total of 166 nursing home leaders participated in the survey, 47 representing AL nursing homes, 40 representing GA nursing homes, 25 representing MS nursing homes and 54 representing TN nursing homes. The characteristics of the sample are presented in Table 8 (below), which includes all participants providing responses to each item (regardless of the number of items completed by a particular participant). The average participant was a White administrator with a mean age of 50. Although the overall sample was predominately composed of women, there were more men than women who completed the survey in the state of TN. The leaders from AL nursing homes were younger than those from other states; AL leaders were also more likely to be African American than participants from other states. Approximately half of the sample held a bachelors degree, and less than one third held advance level degrees. Participants tended to have a degree in nursing/health or administration. Several participants held multiple degrees, and they were more likely to hold a degree in health or administration and some other disciple.

Table 8

Descriptive Statistics of Study Sample

Demographic Variable *M* (*SD*) or *N* (%)	AL	GA	MS	TN	Total
Position					
Administrator	44 (93.6%)	35 (87.5%)	22 (91.7%)	51 (94.4%)	152 (92.1%)
Assist. Administrator	1 (2.1%)	1 (2.5%)	--	--	2 (1.2%)
Director of Nursing	2 (4.3%)	4 (10.0%)	2 (8.3%)	3 (5.6%)	11 (6.7%)
Sex					
Male	18 (38.3%)	10 (25.0%)	10 (43.5%)	32 (60.4%)	70 (42.9%)
Female	29 (61.71%)	30 (75.5%)	13 (56.5%)	21 (39.6%)	93 (57.1%)
Age	48.73 (8.9)	52 (8.5)	51 (8.0)	49.49 (9.3)	50.4 (8.9)
Race					
White	40 (85.1%)	37 (92.5%)	22 (91.7%)	50 (92.6%)	149 (90.3%)
African American	6 (12.8%)	3 (7.5%)	1 (4.2%)	4 (7.4%)	14 (8.5%)
Hispanic	1 (2.1%)	--	1 (4.2%)	--	2 (1.2%)
Country of Origin					
USA	46 (97.9%)	40 (100%)	21 (95.5%)	50 (96.2%)	157 (97.5%)
Other	1 (2.1%)	--	1 (4.5%)	2 (3.8%)	4 (2.5%)
Education					
Doctoral degree	1 (2.1%)	1 (2.5%)	--	1 (1.9%)	3 (1.8%)
Masters degree	16 (34.0%)	9 (22.5%)	6 (26.1%)	16 (30.2%)	47 (28.8%)
Bachelors degree	20 (42.6%)	16 (40%)	11 (47.8%)	32 (60.4%)	79 (48.5%)
Associated degree	10 (21.3%)	9 (22.5%)	3 (13.8%)	2 (3.8%)	24 (14.7%)
Some college	--	2 (5.0%)	2 (8.7%)	1 (1.9%)	5 (3.1%)
HS/trade/other	--	3 (7.5%)	1 (4.3%)	1 (1.9%)	5 (3.1%)
Discipline					
Nursing/health	13 (27.7%)	17 (44.7%)	6 (26.1.%)	9 (16.7%)	45 (27.8%)
Business/management	12 (25.5%)	8 (21.1%)	8 (34.8%)	14 (25.9%)	42 (25.9%)
Social work	4 (8.5%)	2 (5.3%)	2 (8.7%)	2 (3.7%)	10 (6.2%)
Health administration	10 (21.3%)	2 (5.3%)	2 (8.7%)	10 (18.5%)	24 (14.8%)
Social sciences	1 (2.1%)	1 (2.6%)	1 (4.3%)	2 (3.7%)	5 (3.1%)
Other	1 (2.1%)	1 (2.6%)	4 (17.4%)	7(13.8%)	13 (8.0%)
Multiple disciplines	6 (12.8%)	7 (18.4%)	--	10 (18.5%)	23 (14.2%)
Years at current NH	9.8 (8.9)	8.3 (8.7)	7.0 (6.0)	7.9 (8.0)	8.4 (8.2)
Years in current Job Title	12.9 (10.2)	11 (8.7)	16.8 (9.3)	14.7 (9.3)	13.8 (9.5)
Years in Long-Term Care	19.2 (9.0)	20 (9.9)	19.8 (7.0)	19.9 (9.0)	19.7 (8.9)

Note. There were missing data for the following variables: (a) position: 5 (b) sex: 7; (c) age: 15; (d) race: 5; (e) country of origin: 9; (f) education: 7; (g) discipline: 8; (h) years at facility: 7; (i) years in current job: 6; (j) years in long-term care: 11.

Table 9 compares the facilities represented by survey participants to those of non-participants on several variables available on the Nursing Home Compare website (https://data.medicare.gov/data/nursing-home-compare). The facilities represented by participants consisted of predominately for-profit, chain affiliated nursing homes in urban areas. The average bed size of facilities represented by participants was around 100 with an occupancy rate of 86%. The facilities were largely located in communities where minorities comprised approximately one-third of the population.

Table 9

Characteristics of Survey Participants vs. Non-Participants

Characteristics *M* (*SD*) or *N* (%)	Participants *N* = 152	Non-participants *N* = 955
Profit status		
For-profit	97 (63.8%)	720 (75.4%)
Non-profit	37 (24.3%)	175 (18.3%)
Government*	18 (11.8%)	60 (6.3%)
Chain affiliation		
Chain affiliated	90 (59.2%)	629 (65.9%)
Independent	62 (40.8%)	326 (34.1%)
Geographic location		
Urban focused	79 (52.0%)	474 (49.6%)
Large rural city focused	27 (17.8%)	192 (20.1%)
Small rural town focused	24 (15.8%)	187 (19.6%)
Isolated small rural town focused	22 (14.5%)	102 (10.7%)
Number of residents	92.1 (47.4)	94.6 (42.9)
Bed size	106.1 (52.3)	110 (50.3)
Occupancy rate	86.1 (14.3)	86.5 (17.2)
Community racial composition (% White)	66.1 (24.2)	66.2 (24.0)

*$p < .05$

The facilities represented by the survey participants were not significantly different from those represented by non-participants based on chain affiliation, number of residents, bed size, occupancy rate, geographic location, or community racial composition. There was, however, a significant difference between participants and non-participants based on profit status, χ^2 (1, n = 1107) = 10.61, p = .005, □ = .09. Specifically, there were a higher percentage of respondents from government facilities compared to respondents from for-profit and non-profit facilities.

Aim 1

The first aim sought to examine how nursing home leaders understand and characterize workforce diversity. The participants were asked to respond to items assessing perceptions of the components of diversity (Item 24). Each leader was asked to indicate whether they believed WD was substantially different from EEO/AA (Item 36). The participants' attitudes and perceptions of diversity were also assed by the R-T-D Inventory (Item 23). Two exploratory survey items asked leaders to indicate the availability of translation services (Item 13) as well as their experiences with racial discrimination (Item 35). Descriptive statistics were computed for each of these items. Additionally, a chi-square analysis was conducted based on the results of Item 36.

Concept of diversity. To measure the leaders' perceptions of the components of diversity, each participant reviewed a list of 12 words and selected all the words they believed were "included in the concept of diversity" (Item 24; see Appendix A). The results are summarized in Table 10 (below). Approximately 37% of the sample indicated that all 12 words were included in the concept of diversity. When responses were examined by the categories of "primary" or "secondary" (see page 56 for discussion of this concept), the primary terms ranked highest in "yes" responses, with at least 84% of participants indicating they included these terms in the concept of diversity. This finding supports the first hypothesis (H_1) that nursing home

leaders will narrowly define the definition of workforce diversity. Secondary characteristics received "yes" responses that ranged from 84% to 65%. Education was included in the concept of diversity by 74% of participants and income by 52% of participants. Income and sexual orientation received the highest "no" responses, while income, regional/geographic location, and sexual orientation were among the characteristics that individuals were most uncertain about their relationship with the concept of diversity.

Table 10

Descriptive Statistics for Components of Diversity Responses

Rank	Characteristic	Yes *N* (%)	No *N* (%)	Uncertain *N* (%)
1.	Culture/ethnicity[a]	127 (94.8%)	5 (3.7%)	2 (1.5%)
2.	Race[a]	126 (94.0%)	7 (5.2%)	1 (0.7%)
3.	Age[a]	121 (90.3%)	13 (9.7%)	--
4.	Gender[a]	118 (88.1%)	14 (10.4%)	2 (1.5%)
5.	National origin[a]	113 (84.3%)	13 (9.7%)	8 (6.0%)
6.	Language differences[b]	113 (84.3%)	15 (11.2%)	6 (4.5%)
7.	Religion[b]	111 (82.8%)	18 (13.4%)	5 (3.7%)
8.	Handicap/physical ability[b]	111 (82.8%)	15 (11.2%)	8 (6.0%)
9.	Education[b]	99 (73.9%)	31 (23.1%)	4 (3.0%)
10.	Regional/geographic location[b]	91 (67.9%)	31 (23.1%)	12 (9.0%)
11.	Sexual orientation[b]	87 (64.9%)	37 (27.6%)	10 (7.5%)
12.	Income[b]	69 (51.5%)	54 (40.3%)	11 (8.2%)

Note. The data presented only includes the 134 participants who provided a response to each diversity characteristic included on the survey. There were 36 respondents with missing data for this item.
[a] Represents a primary characteristics that is included in the definition of EEO/AA.
[b] Represents a secondary characteristics

Meaning of diversity. The meaning of diversity was investigated by an item that asked, "is WD substantially different from EEO/AA programs in scope?" (Item 36; see Appendix A).

Table 11 (page 77) summarizes the responses for this survey item. Nearly half (46%) of the respondents did not believe WD was substantially different from EEO/AA programs. Of the 18% who reported a difference between WD and EEO/AA, 18 individuals elaborated on their perception of the differences. The participants distinguished WD from EEO/AA in three ways 1) actions/efforts by the organization to diversify; 2) inclusiveness of various demographic groups, including those not specific to race; and 3) limitations of EEO/AA to rules and regulations. A summary of the most complete and compelling responses is listed in Table 12 (page 78).

A chi-square test for goodness of fit was conducted to test whether the current sample responded to the EEO/AA vs. WD item similarly to a sample from a previous study conducted by Carrell et al. (2006). The results are displayed in Table 11 (below). The observed frequency data represent the responses obtained from Item 36. The expected frequency data represent the frequencies one might expect if the participants in the current study responded to the question in the same manner as those in the comparison study. The results revealed there was a significant difference between the responses in the current sample as compared with a previous longitudinal study of U.S. employees by Carrell and colleagues (2006), χ^2 (2, n = 143) = 26.93, p < .001. In reviewing Table 11, the results suggest that in comparison to the Carrell et al. (2006) study more people in the current sample than expected responded “no” and more people than expected responded “uncertain,” whereas less people than expected responded “yes.” These differences could imply that nursing home leaders are less knowledgeable on the meaning of diversity than other disciplines.

Table 11

Meaning of Diversity Chi-Square Goodness-of-Fit Test Frequencies

Is WD substantially different from EEO/AA programs? *N* (%)	Observed Frequency O_i	Expected Frequency E_i	$(O_i - E_i)^2/E_i$	*Df*	Say. Sig.
Yes	25 (17.5%)	54.3 (37.8%)	15.8		
No	65 (45.5%)	52.9 (37.1%)	2.8		
Uncertain	53 (37.1%)	35.8 (25.2%)	8.4		
Pearson Chi-square			$\chi^2 = 26.9$	2	.000*

Note. The results presented here include the 143 individuals who responded to this survey item. There were 27 respondents with missing data for this item.

* $p < .001$.

Table 12

Meaning of Diversity Qualitative Responses

Category	Quote
Dependency on organizational efforts to diversify	*Workforce diversity is the assessment and reality of workplace and the ability to build plans and make enhancements based on the workplace diversity that a facility has*
	Can vary from organization to organization dependent upon the vision of the company
Inclusiveness of various demographic groups	*We do not discriminate against anyone for any reason. We treat every application the same. I am treating WD differently because although we support WD, our jobs typically are filled with the same diverse groups of people. We are not going to screen out or select certain groups of people so we can be a diverse place to work. We will seek and hire the most qualified individuals for each job. However, we recruit in ways where anyone can apply. We recently signed up for the local veterans job fair seeking quality individuals for employment. We chose to attend the job fair not based on diversity, but as another avenue to recruit employees.*
	WD encompasses much more than race in employment it also encompasses religions, culture, sex, sexual preference, etc.
	Various background vs. equality
	I think EEO/AA is just for racial differences where WD encompasses lots of differences
	Four generations are working together in today's workforce. Each generation brings a diverse work ethic & style to the table.
Constrained to rules and regulations	*EEO/AA programs apply requirements and regulations governing employment practices. In my opinion, the goal of achieving workplace diversity is a desirable by-product of assembling a team of dedicated employees, each of which brings their own unique array of traits/background/perspectives to the work environment, but together perform at a high level*
	WD is an internal effort yielding benefits EEO is an outside program supported by penalties and fear. AA is an outdated concept
	Teaches instead of regulates
	I think of WD as more of a culture in an organization rather than an actual policy or regulation.
	I feel it is a broader base from which to work. EEO and AA are fairly limiting.

Reaction-To-Diversity (R-T-D) Inventory. The mean R-T-D scores are displayed in Table 13. According to previous studies, the R-T-D Inventory has good internal consistency, with a Cronbach's alpha coefficient of α = .78 (De Meuse et al., 2007; Hostager & De Meuse, 2002, 2008; Thomas, 2008). In the current study, the Cronbach's alpha coefficient was α = .87. The total scores ranged from -11 to 32. The average R-T-D score was 9.6, which is descriptively classified in the realist/neutral range; the average scores for each state also fell in this category (see footnote, Table 13 for descriptive category definitions). There were no significant differences between R-T-D scores by state, F (3, 146) = 1.66, p = .47. The results only partially support the predictions made in the first hypothesis (H_1) that nursing home leaders' scores on a scale measuring WD attitudes would fall within the neutral to negative classification range. On average, individuals selected 14.1 (SD = 9.0) positive words and 4.3 (SD = 5.5) negative words. Regarding R-T-D descriptive categories, scores in the realist/neutral range comprised just over half (53%) of the sample (see Table 13), with the rest of the sample scoring in the optimist/positive range (excepting one person from the sample of 150 persons who scored in the pessimist/negative range).

Table 13

Reaction-to-Diversity Inventory Descriptive Categories Results

Descriptive Category	AL N = 40	GA N = 36	MS N = 24	TN N = 50	Total N = 150
Optimist/positive	18 (45.0%)	14 (38.9)	14 (6.9%)	23 (46.0%)	69 (46.0%)
Realist/neutral	22 (55.0%)	21 (58.3%)	10 (41.7%)	27 (54.0%)	80 (53.3%)
Pessimist/negative	--	1 (2.8%)	--	--	1 (0.7%)

Note. Optimist/positive scores = +11 to +35; Realist/neutral scores = -10 to +10; and Pessimist/negative scores = -35 to -11

Examination of the R-T-D Dimensions (Table 14, page 81) revealed that the dimensions of behavioral reactions and judgment had the two highest subscale scores, suggesting that leaders had more positive attitudes toward diversity related to what they do in response to WD, and related to the value judgments they place on WD. The dimension of personal consequences of WD had the lowest average score across all four states, indicating that leaders tend to have more negative beliefs related to perceived diversity outcomes and how they will be affected by these outcomes. This was likely due to the high number of negative words circled in this dimension (see Table 15 below), as the total count of negative personal consequences items circled was higher than any other negative category (See Item 23 in Appendix A). Participants circled more words from the behavioral reactions and personal consequences dimensions than the other three dimensions (See Table 15 below).

Table 14

Descriptive Statistics for Reaction-to-Diversity Inventory Total and Dimension Scores

	AL *N* = 40		GA *N* = 36		MS *N* = 24		TN *N* = 50		Total *N* = 150	
Variable	*M (SD)*	Range	*M (SD)*	Range	*M (SD)*	Range	*M (SD)*	Range	*M (SD)*	Range
R-T-D Total Score	9.2 (9.1)	-6–29	7.4 (8.2)	-11–27	11.92 (7.6)	-4–24	9.6 (8.8)	-7–32	9.6 (8.8)	-11–32
R-T-D Dimensions										
Emotional Reactions	1.4 (2.3)	-3–7	1.5 (1.9)	-3–6	1.96 (2.2)	-3–6	1.6 (2.2)	-2–7	1.6 (2.2)	-3–7
Behavioral Reactions	2.6 (2.4)	-2–7	2.2 (2.4)	-2–7	3.5 (2.1)	0–6	2.6 (2.4)	-3–7	2.6 (2.4)	-3–7
Judgments	2.8 (2.3)	-1–7	1.9 (1.7)	-2–6	2.8 (1.7)	0–6	2.5 (2.0)	-3–5	2.5 (2.0)	-3–7
Personal Consequences	0.9 (2.4)	-5–6	.61 (2.7)	-5–6	1.3 (2.2)	-2–5	1.2(2.4)	-3–7	1.2 (2.4)	-5–7
Organizational Outcomes	1.5 (2.1)	-3–7	1.2 (1.7)	-3–5	2.4 (1.8)	-2–6	1.8 (2.0)	-1–7	1.8 (2.0)	-3–7

Note. There were 20 participants with missing data for the R-D-T.

Table 15

Items Representing the Reaction-to-Diversity Inventory Dimensions and the Number of Times Participants Circled Each Item

	Emotional Reactions Dimension		Behavioral Reactions Dimension		Judgments Dimension		Personal Consequences Dimension		Organizational Outcomes Dimension	
N = 150	*N* (%)		*N* (%)		*N* (%)		*N* (%)		*N* (%)	
Positive words	106 (70.7%)	Compassionate	67 (44.7%)	Collaborate Cooperate	77 (51.3%)	Ethical	42 (28.0%)	Advancement	58 (38.7%)	Asset
	43 (28.7%)	Enthusiastic	77 (51.3%)		69 (46.0%)	Fair	30 (20.0%)	Discovery	63 (42.0%)	Harmony
	30 (20.0%)	Excited	94 (62.7%)	Friendly	92 (61.3%)	Good	60 (40.0%)	Enrichment	44 (29.3%)	Innovation
	45 (30.0%)	Grateful	67 (44.7%)	Listen	21 (14.0%)	Justified	22 (14.7%)	Merit	31 (20.7%)	Profitable Progress
	51 (34%)	Happy	58 (38.7%)	Participate	35 (23.3%)	Proper	86 (57.3%)	Opportunity	57 (38.0%)	
	56 (37.3%)	Hopeful	79 (52.7%)	Support	54 (36.0%)	Sensible	92 (61.3%)	Rewarding	100 (66.7%)	Team-building
	79 (52.7%)	Proud	57 (38.0%)	Understand	60 (40.0%)	Useful	52 (34.7%)	Wisdom	53 (35.3%)	Unity
Negative words	16 (10.7%)	Anger	19 (12.7%)	Blame	2 (1.3%)	Bad	30 (20%)	Clashes	19 (12.7%)	Bureaucratic
	28 (18.7%)	Apprehensive	4 (2.7%)	Fight	6 (4.0%)	Immoral	24 (16.0%)	Insecurity	6 (4.0%)	Disorder
	23 (15.3%)	Confused	10 (6.7%)	Patronize	13 (8.7%)	Unfair	36 (24.0%)	Pressure	13 (8.7%)	Expensive
	19 (12.7%)	Disagree	21 (14.0%)	Resist	9 (6.0%)	Unjustified	18 (12.0%)	Rivalry	20 (13.3%)	Liability
	19 (12.7%)	Fear	23 (15.3%)	Stubbornness	2 (1.3%)	Unnatural	29 (19.3%)	Sacrifice	47 (31.3%)	Regulations
	37 (24.7%)	Frustration	15 (10.0%)	Unfriendly Withdrawal	3 (2.0%)	Useless	9 (6.0%)	Sleeplessness	30 (20.0%)	Turnover
	22 (14.7%)	Resentment	3 (2.0%)		3 (2.0%)	Worthless	61 (47.7%)	Stress	5 (3.3%)	Unprofitable
TOTALS	574 (20.87%)		594 (21.59%)		446 (16.21%)		591 (21.48%)		546 (19.85%)	

Note: The data presented correspond the total number and percentage of participants who circled the word

Additional exploratory items. Table 16 (below) illustrates the results of the two exploratory items assessing translation services and experiences with discrimination. Over a third of the nursing homes reported they offered translation services, with 80% of the facilities having two or more types of services available. Only five facilities in this sample had a full-time medical translator on staff. An independent-samples t-test was conducted to compare the community racial composition of facilities with versus those without translation services. The difference in community racial composition for facilities offering translation services (M = 30.09, SD = 21.04) and those that did not (M = 40.88, SD = 29.46) was significant, t (160) = -2.39, p = .02, η^2 = .03, which indicated that facilities located in communities with a higher minority population were more likely to offer translation services.

Very few leaders reported they had experienced workplace racial discrimination. There were no significant differences in community racial composition scores between individuals that had experienced discrimination (M = 41.28, SD = 25.29), those who had not (M = 31.34, SD = 23.29), and those who were uncertain (M = 33.36, SD = 23.93), F (2, 140) = 1.98, p = .14.

Table 16

Descriptive Statistics for Additional Exploratory Items: Translation Services and Experiences with Racial Discrimination

Variable *N* (%)	AL *N* = 47	GA *N* = 40	MS *N* = 24	TN *N* = 54	Total *N* = 165
Translation services available (% Yes)	25 (53.2%)	31 (77.5%)	15(62.5%)	41 (75.9%)	112 (67.9%)
Type of service available	AL *N* = 25	GA *N* = 31	MS *N* = 15	TN *N* = 41	Total *N* = 112
Bilingual employees	8 (32.0%)	19 (61.3%)	6 (40.0%)	23 (56.1%)	56 (50.0%)
Full-time trained medical translator	3 (12.0%)	1 (3.2%)	--	1 (2.4%)	5 (4.5%)
Language banks	18 (72.0%)	20 (64.5%)	11 (73.3%)	31 (75.6%)	80 (71.4%)
Experienced discrimination	AL *N* = 38	GA *N* = 34	MS *N* = 23	TN *N* = 49	Total *N* = 144
Yes	7 (18.4%)	4 (11.8%)	4 (17.4%)	4 (8.2%)	19 (13.2%)
No	27 (71.1%)	28 (82.4%)	18 (78.3%)	44 (89.8%)	117 (81.3%)
Uncertain	4 (10.5%)	2 (5.9%)	1 (4.3%)	1 (2.0%)	8 (5.6%)

Note. There were 5 (GA: 3, MS 2) respondents with missing data for the translation services item. There were 26 (AL: 9, GA: 9, MS 3, TN: 5) respondents with missing data for the discrimination item.

Aim 2

The second aim sought to explore leader reports of specific diversity management practices currently being implemented in nursing home facilities. The participants were asked to respond to items assessing diversity management policies and practices (Items 25-34). Each leader was asked to identify activities he/she associated with diversity (Item 37) and also indicate which sources initiate diversity policies, programs and discussions (Item 38). Descriptive statistics were computed for each of these items.

Diversity management. Table 17 (page 86) displays the results from the 10-item diversity management scale (Items 24-34). Approximately half of the respondents either agreed

or strongly agreed with Item 25 (“the racial/ethnic demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area”). However, only 19% agreed or strongly agreed with the next item regarding if organizational levels (e.g., executive, management, professional, service) are routinely compared in terms of racial composition. The majority of respondents strongly agreed that employee satisfaction evaluations were routinely compared across racial/ethnic groups. Two-thirds of the leaders disagreed or strongly disagreed that literacy, GED, English, or foreign language classes were offered at no charge to employees.

Table 17

Descriptive Statistics for Diversity Management Scale Individual Item Responses

Diversity management scale item *N* = 144	Strongly Agree *N* (%)	Agree *N* (%)	Neither Agree or Disagree *N* (%)	Disagree *N* (%)	Strongly Disagree *N* (%)	Mean Rating *M* (*SD*)
25. The racial/ethnic demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area.	20 (13.9%)	51 (35.4%)	45 (31.3%)	23 (16.0%)	5 (3.5%)	3.4 (*1*)
26. Racial/ethnic demographics of the workforce are routinely compared by level (executive, management, professional, and service).	4 (2.8%)	23 (16.0%)	74 (51.4%)	30 (20.8%)	13 (9.0%)	2.8 (*0.9*)
27. Employee satisfaction is routinely evaluated and compared among all racial/ethnic groups.	56 (38.9%)	34 (23.6%)	36 (25.0%)	11 (7.6%)	7 (4.9%)	3.8 (*1.2*)
28. Diversity training is designed in response to systematic assessment of the racial/ethnic diversity climate and culture.	14 (9.7%)	44 (30.6%)	61 (42.4%)	16 (11.1%)	9 (6.3%)	3.3 (*1.0*)
29. Diversity training is provided frequently.	8 (5.6%)	47 (32.6%)	54 (37.5%)	29 (20.1%)	6 (4.2%)	3.2 (0.9)
30. Racially/ethnically diverse employees with potential for advancement are systematically identified and supported.	24 (16.7%)	59 (41.0%)	48 (33.3%)	10 (6.9%)	3 (2.1%)	3.6 (*0.9*)
31. Prospective employees are interviewed by a team that is diverse by race/ethnicity.	12 (8.3%)	49 (34.0%)	47 (32.6%)	28 (19.4%)	8 (5.6%)	3.2 (*1.0*)
32. Formal mentoring programs are emphasized.	23 (16.0%)	64 (44.0%)	39 (27.1%)	12 (8.3%)	6 (4.2%)	3.6 (*1.0*)
33. Management talks openly about issues of race/ethnicity.	14 (9.7%)	53 (36.8%)	57 (39.6%)	14 (9.7%)	6 (4.2%)	3.4 (*0.9*)
34. Literacy, GED, English, or foreign language classes are offered at no charge to all employees.	6 (4.2%)	4 (2.8%)	41 (28.5%)	58 (40.3%)	35 (24.3%)	2.2 (*1.0*)

Note. There were 26 (AL: 9, GA: 10, MS: 3, TN: 4) respondents with missing data for this item.

The mean diversity management scale total scores are displayed in Table 18 (below). This score was derived by summing and then averaging the scores for Items 25-34 (See Appendix A for survey items; see page 61 for more information regarding scoring these items). The scale appears to have acceptable internal consistency, with a Cronbach's alpha coefficient of $\alpha = .78$. There were no significant differences in the total scale scores by state F (3, 140) = .74, p = .53. When diversity training was provided, managers/supervisors and nursing and other caregivers were the most frequently reported attendees. Physicians were least likely to participate in diversity training. Tennessee facilities seemed to have the highest percentage of participation in diversity training for four of the five employee categories—Alabama appeared to have the highest participation of physicians. Half of the facilities reported taking corrective action when the job offers or turnover ratios vary by race/ethnicity, while less than half take correction action when the workplace racial composition ratios vary by organizational level.

Table 18

Descriptive Statistics for Diversity Management Scale Total Scores and Supplemental Item Responses

Variable *M* (*SD*) or *N* (%)	AL *N* = 38	GA *N* = 33	MS *N* = 23	TN *N* = 50	Total *N* = 144
Diversity management scale total score	3.2 (0.5)	3.3 (0.6)	3.2 (0.5)	3.3 (0.6)	3.2 (0.6)
Employees who participate in training (% Yes)	AL *N* = 38	GA *N* = 34	MS *N* = 24	TN *N* = 50	Total *N* = 146
Non-clinical staff	21 (55.3%)	25 (73.5%)	12 (50%)	39 (78.0%)	97 (66.9%)
Managers and other supervisors	27 (71.1%)	28. (82.4%)	15 (62.5%)	40 (80.0%)	110 (75.3%)
Nurses and other caregivers	24 (63.2%)	27 (79.4%)	12 (54.2%)	40 (80.0%)	104 (71.2%)
Executives	19 (50.0%)	17 (50.0%)	10 (41.7%)	30 (60.0%)	76 (52.1%)
Physicians	5 (13.2%)	3 (8.8%)	2 (8.3%)	6 (12.0%)	16 (11.0%)
	AL *N* = 35	GA *N* = 34	MS *N* = 22	TN *N* = 45	Total *N* = 136
Corrective action taken when employee job offers or turnover ratios vary by race/ethnicity: (% Yes)	19 (54.3%)	14 (41.2%)	9 (40.9%)	26 (57.8%)	68 (50.0%)
	AL *N* = 34	GA *N* = 33	MS *N* = 20	TN *N* = 43	Total *N* = 130
Corrective action taken when the racial/ethnic composition of the workforce varies by level: (% Yes)	12 (35.3%)	13 (39.4%)	7 (35.0%)	18 (41.9%)	50 (38.5%)

Note. The diversity management score could not be calculated for 26 (AL: 9, GA: 10, MS: 3, TN: 4) respondents due to missing data. There were 24 (AL: 9, GA: 9, MS: 2, TN: 4) respondents with missing data for the training item; 34 (AL: 12, GA: 9, MS: 4, TN: 9) missing respondents for the turnover ratio item; and 40 (AL: 13, GA: 10, MS: 6, TN: 11) missing respondents for the racial composition by level item.

Activities associated with diversity management. Table 19 shows the activities that nursing home leaders associated with diversity (Item 37). Approximately 7% of the sample selected all 10 activities as being associated with diversity policies and programs within their organization. Recruitment and customer service were most frequently reported as activities associated with diversity. Career management and language training were the least frequently reported activities.

Table 19

Descriptive Statistics for Activities Associated with Diversity Management Responses

Activities associated with diversity policies and programs, *N* (Yes %)	AL *N = 38*	GA *N = 34*	MS *N* = 22	TN *N* = 50	Total *N* = 144
Recruitment	18 (47.4%)	20 (58.8%)	9 (40.9%)	33 (66.0%)	80 (55.6%)
Customer services	18 (47.4%)	26 (76.5%)	10 (45.5%)	25 (50.0%)	79 (54.9%)
Communication/interpersonal skills	14 (36.8%)	23 (67.6%)	6 (27.3%)	17 (34.0%)	60 (41.7%)
Sensitivity training	12 (31.6%)	15 (44.1%)	8 (36.4%)	24 (48.0%)	59 (41.0%)
Awareness training	15 (39.5%)	15 (44.1%)	9 (40.9%)	18 (36.0%)	57 (39.6%)
Selection	14 (36.8%)	12 (35.3%)	8 (36.4%)	21 (42.0%)	55 (38.2%)
Skills enhancement/in-service education	15 (39.5%)	16 (47.1%)	7 (31.8%)	15 (30.0%)	53 (36.8%)
Workshops on issues	8 (21.1%)	4 (11.8%)	8 (36.4%)	12 (24.0%)	37 (25.7%)
Career management	4 (10.5%)	4 (11.8%)	3 (13.6%)	11 (22.0%)	22 (15.3%)
Language training	3 (7.9%)	3 (8.8%)	3 (13.6%)	6 (12.0%)	15 (10.4%)

Note. There were 26 (AL: 9, GA: 9, MS 4, TN: 4) respondents with missing data for this item.

The leaders were allowed to write in "Other" activities that were not listed on the survey; only four participants responded to this item. One leader in Tennessee listed Title IV programs as

another activity associated with diversity; whereas three others used this open-ended response item to discuss their opinions regarding diversity in the workplace: a Mississippi leader responded, "*skin pigmentation is irrelevant—character, experience and skills matter.*"; a Tennessee leader stated, "*We try to hire the best person for the job based on experience, not quotas.*"; finally, a Tennessee leader wrote, "*We do not have a formal diversity policy.*"

It appears that there is some concurrence between reported management strategies and federal and state nursing home requirements, as the third most frequently reported activity was communication/interpersonal skills, which is one of the CMS required trainings for CNAs. Language training and in-services were additional activities that might be associated with the CMS requirements, but these activities were not as commonly reported to be associated with diversity.

Sources of diversity management. Table 20 (below) displays the results for item 38, which inquired regarding who initiates diversity policies, programs, or discussions. Human resources personnel and the facility leadership (i.e. corporate officers, administrators, and DONs) were the most frequently reported staff members to introduce diversity management initiatives. On the other hand, the direct care staff and EEO/AA departments were the least cited sources of diversity. It should be noted that having an EEO/AA departments is likely to be rare in a nursing home facility and is likely only associated with facilities that belong to a larger overarching structure: of the 4 individuals that reported having an EEO/AA department in their facility, three were for-profit corporations and the fourth was a city/county government facility.

Table 20

Descriptive Statistics for Sources of Diversity Management Responses

Variables *N* (Yes%)	AL *N* = 39	GA *N* = 34	MS *N* = 22	TN *N* = 50	Total *N* = 145
Human resources/ professional development	19 (48.7%)	19 (55.9%)	11 (50.0%)	32 (64.0%)	81 (55.9%)
Administrator	12 (30.8%)	20 (58.8%)	12 (54.5%)	25 (50.0%)	69 (47.6%)
CEO/corporate officers	16 (41.0%)	13 (38.2%)	11 (50.0%)	18 (36.0%)	58 (40.0%)
Director of nursing	7 (17.9%)	11 (32.4%)	6 (27.3%)	10 (20.0%)	34 (23.4%)
Mid-level managers/supervisors	6 (15.4%)	6 (17.6%)	4 (18.2%)	9 (18.0%)	25 (17.2%)
Board of directors	3 (7.7%)	2 (5.9%)	4 (18.2%)	7 (14.0%)	16 (11.0%)
Nursing & direct care staff	3 (7.7%)	4 (11.8%)	3 (13.6%)	3 (6.0%)	13 (9.0%)
EEO/AA departments	1 (2.6%)	1 (2.9%)	0 (0%)	2 (4.0%)	4 (2.8%)

Note. There were 25 (AL: 8, GA: 9, MS 4, TN: 4) respondents with missing data for this item.

Written diversity policies and programs. There appeared to be some confusion about how to respond to the item "does your nursing home have a written policy or program that includes the concept of diversity" (Item 39) on the paper survey. The survey was designed for individuals to respond yes or no. If "yes," they were then supposed to answer 39a (*Does your policy address the concept of diversity? If yes, please explain*) to end the survey. If the response to item 39 was "no," they were supposed to respond to 39b (*Are you aware of any policies being implemented, in planning, or under discussion?*) to end to survey. However, 20 leaders replied to all three items. An additional 18 leaders did not provide a response to item 39 but responded to both 39a and 39b.

Of the 121 leaders who correctly responded to these three items, 80 respondents (66%) indicated they had a written policy or program that included the concept of diversity, and of these fifteen leaders (19%) stated their policy addressed the concept of diversity beyond the

concept of EEO/AA. For the 41 leaders who did not have a written diversity policy or program, 5 of these leaders indicated they were aware of new policies being implemented, in planning, or under discussion. The results presented in Table 21 include the results for each individual response item by state. Two-thirds of the leaders reported having a written policy or program that includes the concept of diversity. The Georgian and Tennessee respondents reported the highest frequency of facilities with written diversity programs or policies. There were only a small number of respondents reporting facilities with policies that addressed diversity beyond the concept of EEO/AA programs, and still fewer who were aware of new diversity policies being implemented, in planning or under discussion. Table 22 (page 93) displays the open-ended responses for the 11 leaders indicating their diversity programs and policies addressed diversity beyond the concept of EEO/AA programs. The data are divided into responses that appear to address diversity beyond EEO/AA and those that include statements that are more similarly related to EEO/AA programs.

Table 21

Descriptive Statistics for Written Policies or Programs that Include the Concept of Diversity

Survey Item *N* (% Yes)	AL N = 31	GA N = 31	MS N = 19	TN N = 43	Total N = 124
39. Does your nursing home have a written policy or program that includes the concept of diversity	14 (45.2%)	22 (71.0%)	11 (57.9%)	35 (81.4%)	82 (66.1%)
	AL N = 20	GA N = 25	MS N = 13	TN N = 42	Total N = 100
39a. Does your policy address the concept of diversity beyond the concept of EEO/AA?	2 (10.0%)	4 (16.0%)	0 (0%)	14 (33.3%)	20 (20.0%)
	AL N = 25	GA N = 15	MS N = 11	TN N = 21	Total N = 72
39b. Are you aware of any new policies being implemented, in planning, or under discussion?	1 (4.0%)	3 (20.0%)	1 (9.1%)	1 (4.8%)	6 (8.3%)

Note. There were 46 missing responses for item 39; 28 missing responses for item 39a; and 27 missing responses for item 39b.

Table 22
Responses to Question about Policies Addressing Diversity Beyond Equal Employment Opportunity/Affirmative Action

Theme	Quote
Written policies or programs that address diversity beyond EEO/AA	*Valuing diversity is not only a legal, social, and moral issue; it is also an economic issue because our most valuable resource is our employees. Enhancing our cultural diversity is an organizational wide endeavor. We will strive to identify and eliminate all discriminatory barriers that limit applicants and employees. Programs have been instituted to facilitate the process of a numerically balanced diverse workforce. We promote a culture that values and enhances diversity. The hospital periodically conducts training programs that are designed to educate managers and other employees about workforce diversity. These training programs include training pertaining to gender, age, race, physical and mental abilities and sexual orientation. Other training dimensions include religious beliefs, ethnic customs, communication styles and parental status.*
	Related to providing proper care by understanding cultural diversity
	Looks at each individual back ground and how perception plays role of actions. Sensitivity not just "roles"
	Extremely well done webinars and computerized training is required of all employees
	Employee handbooks emphasizes we believe in the concept and ignores EEO/AA statements
Written policies or programs that encourage equality and prevent discrimination	*Equal Opportunity housing with HUD*
	Applicable policies are written so to reinforce non-discrimination and prevent discrimination
	Anti-discrimination policy
	All ads contain EEOC statement
	Our company has OFCCP (Office of Federal Contract Compliance Programs) policies in place.
	Sexual orientation

Note. These are the open-ended responses from individuals who responded yes to Item 39a (see Appendix A). There were 9 missing responses for this item.

Aim 3

The third aim was to examine how WD management practices are affected by internal factors including profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition influence. The data sources for-profit status and chain affiliation came from Nursing Home Compare (CMS, 2012), and the information about these variables is described in the Sample Characteristics section (page 71). Information about Medicaid/Medicare census (Items 11-12), culture change adoption (Items 17-22), and workforce racial composition (Items 14-15) came from the survey of nursing home leaders (see Appendix A). Internal factor descriptive statistics are described below followed by results of the regression analysis to determine if the nursing home internal factors would predict diversity management practices.

Internal Factors Descriptive Statistics

Medicaid & Medicare resident census. Medicaid and Medicare resident census descriptive statistics are presented in Table 23 (below). The average Medicaid census reported by the nursing home leaders was 61-80%, meaning the leaders reported that 61-80% of their beds were occupied by residents receiving Medicaid financial assistance for their stay. The Medicaid census rates reported by Mississippi respondents were higher than those of the respondents from the other states (50% of respondents reported that their facilities had Medicaid census levels of 81-100%).

The reported Medicare census rates tended to be lower than the Medicaid census rates, with almost a quarter of the sample reporting that only 0-20% of residents were receiving Medicare financial assistance for their stay. There was a small sample of leaders in MS and TN reporting Medicare Census rates greater than 50%.

Table 23

Descriptive Statistics for Medicaid and Medicare Resident Census

Variable & Percentages	AL *N = 47*	GA *N = 40*	MS *N* = 24	TN *N* = 54	Total *N* = 165
Medicaid Census					
0-20%	4 (8.5%)	1 (2.5%)	1 (4.2%)	7 (13.0%)	13 (7.9%)
21-40%	1 (2.1%)	1 (2.5%)	--	3 (5.6%)	5 (3.0%)
41-60%	10 (21.3%)	6 (15.0%)	1 (4.2%)	12 (22.2%)	29 (17.6%)
61-80%	23 (48.9%)	21 (52.5%)	10 (41.7%)	25 (46.3%)	79 (47.9%)
81-100%	9 (19.1%)	11 (27.5%)	12 (50.0%)	7 (13.0%)	39 (23.6%)
Medicare Census					
0-20%	40 (85.1%)	31 (77.5%)	19 (79.2%)	28 (51.9%)	118 (71.5%)
21-40%	7 (14.9%)	9 (22.5%)	4 (16.7%)	18 (33.3%)	38 (23.0%)
41-60%	--	--	--	1 (1.9%)	1 (0.6%)
61-80%	--	--	--	3 (5.6%)	3 (1.8%)
81-100%	--	--	1 (4.2%)	4 (7.4%)	5 (3.0%)

Note. There were 5 (GA: 3, MS: 2) respondents with missing data for these items.

Culture change adoption. Table 24 (below) shows the results of the 6-item culture change adoption scale. This score was derived by summing and then averaging the scores for items 17-22 (See Appendix A for survey items; see page 62 for more information regarding scoring these items). There were 67 leaders (44.1%) who responded "always" to Item 17 ("*waking times/bed times are chosen by the residents*"). Approximately two-thirds of the respondents indicated their facilities use learning circles (Item 20) either always, often, or sometimes. Over 90% of the leaders responded either often or always to Item 21 regarding whether direct care staff consistently worked with the same residents. Only 8 leaders reported

that a portion of their residents live in self-contained households. The majority of the respondents reported the direct care worker turnover rate for their facility was less than 40%.

The average mean score for the culture change adoptions scale was 3.1 (*SD = 0.5*). The mean scores by state were: Alabama, 3.1 (*SD = 0.4*); Georgia, 3.2 (*SD = 0.5*); Mississippi, 3.2 (*SD = 0.5*); and Tennessee 3.1 (*SD = 0.5*). There were no significant differences in scores by state, F (3, 147) = .73, p = .54. This scale appeared to have poor internal consistency, α = .29; however, this may be the result of the small number of items included in the scale.

Table 24

Descriptive Statistics for Culture Change Adoption Scale Responses

Culture change adoption scale item *N* = 151	Always *N* (%)	Often *N* (%)	Sometimes *N* (%)	Occasionally *N* (%)	Never *N* (%)	Mean Rating *M* (*SD*)
17. Waking times/bed times are chosen by the residents.	67 (44.4%)	60 (39.7%)	22 (14.6%)	1 (0.7%)	1 (0.7%)	4.3 (0.8)
19. A kitchenette or kitchen area with at least a refrigerator and stove is available to families, residents, and staff where cooking and baking are welcomed.	22 (14.6%)	7 (4.6%)	7 (4.6%)	18 (11.9%)	97 (64.2%)	1.9 (1.5)
20. Learning Circles, or their equivalent, are used regularly in staff and resident meetings in order to give each person the opportunity to share their opinion/ideas.	30 (19.9%)	41 (27.2%)	28 (18.5%)	24 (15.9%)	28 (18.5%)	3.1(1.4)
21. Direct care workers consistently work with the same residents or the same group of residents (with no rotation).	47 (31.1%)	93 (61.6%)	4 (2.6%)	1 (0.7%)	6 (4.0%)	4.1 (0.9)
	61-100% *N* (%)	41-60% *N* (%)	21-40% *N* (%)	1-20% *N* (%)	0% *N* (%)	Mean Rating *M* (*SD*)
18. Please indicate the percent of residents who live in households that are self-contained with full kitchen, living room and dining room for the household or unit.[a]	5 (3.3%)	3 (2.0%)	--	--	143 (94.7%)	1.2 (0.8)
	0-19% *N* (%)	20-39% *N* (%)	40-59% *N* (%)	60-79% *N* (%)	80-100% *N* (%)	Mean Rating *M* (*SD*)
22. Please indicate the direct care worker turnover rate for your facility.[b]	60 (39.7%)	47 (31.1%)	27 (17.9%)	16 (10.6%)	1 (0.7%)	4.0 (1.0)

Note. There were 19 (AL: 7, GA: 6, MS: 2, TN: 4) respondents with missing data for this item.
[a] Two respondents reported that 81-100% of their residents live in households
[b] One residents reported his/her facility had a 100+% turnover rate.

Racial composition. The resident racial composition results are displayed in Table 25 (See Item 16 in Appendix A). The residents in the facilities represented in this study were predominantly White (68.9%). African American residents comprised almost a third of the sample. Other minority categories made up less than two percent of the residents in this study.

Table 25

Descriptive Statistics for Resident Racial Composition of the Study Sample

Race	Residents
African American	3,279 (29.5%)
White (not of Hispanic origin)	7,654 (68.9%)
Hispanic	62 (0.6%)
Asian or Pacific Islander	84 (0.8%)
American Indian/Alaskan Native	3 (0.03%)
African/Caribbean	11 (0.1%)
Other/Multiracial	16 (0.1%)
Total	11,109

Table 26 (below) displays the workforce racial composition results (see Items 14 and 15 in Appendix A). The racial composition of the facilities represented in this study was predominantly White (48.8%) and African American (46.8%). Consistent with previous studies, the percentage of African Americans decreased by organizational level, with African Americans accounting for 53.8% of the direct care workers and only 6.1% of the administrators. The direct care staff comprised approximately two-thirds of the total workforce in among the sample.

Table 26
Descriptive Statistics for Workforce Racial Composition of the Study Sample

Race	Direct Care Workers	LPNs	RNs	Unit/Mid-Level Managers	Directors of Nursing	Administrators	Total
African American	4315 (53.8%)	916 (40.7%)	317 (30.9%)	228 (28.2%)	29 (19.9%)	10 (6.1%)	5815 (46.8%)
White	3329 (41.5%)	1254 (55.7%)	664 (64.7%)	552 (68.2%)	111 (76.0%)	149 (94.4%)	6059 (48.8%)
Hispanic	143 (1.8%)	16 (0.7%)	8 (0.8%)	8 (1.0%)	2 (1.4%)	2 (1.2%)	179 (1.4%)
Asian/Pacific Islander	77 (1.0%)	18 (0.8%)	20 (2.0%)	12 (1.5%)	--	--	127 (1.0%)
Amer. Indian/Alaskan Native	4 (0.1%)	4 (0.2%)	3 (0.3%)	--	--	--	11 (0.1%)
African/Caribbean	121 (1.5%)	42 (1.9%)	11 (1.1%)	4 (0.5%)	2 (1.4%)	1 (0.6%)	181 (1.5%)
Other/Multiracial	34 (0.4%)	3 (0.1%)	3 (0.3%)	5 (0.6%)	2 (1.4%)	1 (0.6%)	48 (0.4%)
Total	8023 (64.6%)	2253 (18.1%)	1026 (8.3%)	809 (6.5%)	146 (1.2%)	163 (1.3%)	12420

Note. There were 7 respondents with missing data for race of administrator; 23 for race of director of nursing

Table 27 shows the mean percentage of White employees (by workforce, nursing leadership, and unit managers), residents, and community members for the facility represented in this study. Data from Items 14-17 and the 2010 U.S. Census were used to calculate the proportion of Whites to minorities among each group. On average, 47% of the employees in each facility were White. However, only about one-third of the nursing leadership were White. The percentage of White residents in each facility was 71%, which mirrors the percentage of Whites in the US nationally. On average, the community racial composition of Whites (24%) was lower than national averages. The percentage of Whites in these four states was comparable to the national averages.

Table 27

Descriptive Statistics for Workforce and Community Racial Composition by State

Racial Composition % White *M* (*SD*)	AL N = 35	GA N = 27	MS N = 22	TN N = 45	Total N = 129
Workforce	36.1 (28.4)	38.0 (27.5)	41.6 (25.4)	62.9 (32.0)	46.8 (31.1)
	AL N = 34	GA N = 27	MS N = 22	TN N = 44	Total N = 127
Nursing leadership (unit mangers & RNs)	56.4 (32.0)	59.7 (28.2)	65.4 (23.2)	79.8 (26.5)	66.8 (29.4)
	AL N = 32	GA N = 19	MS N = 17	TN N = 37	Total N = 105
Unit managers	50.0 (36.4)	64.3 (20.6)	61.5 (30.4)	79.5 (28.6)	64.9 (32.2)
	AL N = 34	GA N = 26	MS N = 23	TN N = 44	Total N = 127
Residents	68.6 (26.9)	65.7 (26.2)	67.2 (23.8)	78.0 (25.7)	71.0 (26.1)
	AL N = 220	GA N = 347	MS N = 202	TN N = 318	Total N = 1087
Community	64.1 (25.8)	60.9 (20.5)	53.8 (22.1)	81.4 (19.5)	66.2 (24.0)

Note. There were 41 (AL: 12, GA: 16, MS: 4, TN: 9) respondents with missing data for workforce racial composition and 43 (AL: 13, GA: 17, MS: 3, TN: 10) for resident racial composition. There was missing data to compute the community racial composition for 20 (AL: 8, GA: 9, TN: 3) facilities. A count for missing data was not included for leaders and unit managers, as a non-response for these items could potentially indicate that the facility did not have employees in this work type.

Regression Analyses

The internal factors (profit status, chain affiliation, Medicaid census, culture change adoption, and workforce racial composition) were regressed on to the diversity management scale total score.

Prior to running the regression analysis, two dummy codes were created for-profit status to create dichotomous categorical variables. When creating the dummy codes, non-profit status was used as the baseline comparison group, since it was hypothesized that non-profit nursing homes would have higher diversity management practices. Preliminary analyses were conducted to check for outliers and violations of assumptions of normality, linearity, multicollinearity, homoscedasticity, and independence of residuals. Data screening led to the elimination of two cases. The survey responses for these two cases were consistently extreme, which led to concern about the validity of their scores. The data appear to have violated the assumption of normality, as Kolmogorov-Smirnov statistics for each of the independent variables were all significantly non-normal. However, data transformations were not performed for the following reasons 1) the sample size is relatively small, especially considering that the predicted sample size was 277 and tests of normality are difficult to interpret; and 2) transforming the data can increase the difficulty of the interpretation (Field, 2009). Additionally, the histograms and normal probability plots of the data illustrated roughly normal distributions with only small deviations.

The regression results indicated that the final model significantly predicted diversity management practices, $F = (6, 111) = 4.24$, $p = .001$, accounting for 18.6% of the variance in diversity management practices. Only chain affiliation and culture change adoption significantly contributed to the model; facilities that were a part of a chain had higher diversity management scores, and facilities with higher levels of culture change adoption also had higher diversity

management scores. These results support the second hypothesis that posited nursing home internal factors would predict diversity management practices. However, the results only partially supported the third hypothesis, as only chain affiliation and culture change adoption were significant predictors whereas the other internal factors were not. However, the direction of the two significant internal factors (i.e. chain membership and higher culture change adoption) was in the hypothesized direction. A summary of the regression coefficients is presented in Table 28.

Table 28

Standard Multiple Regression Analysis: Final Model Coefficients for Internal Predictors of Diversity Management Practices

Variables	*B*	*SE B*	*β*
Constant	26.27	3.12	
Chain affiliation	-2.99	1.02	-.28**
Culture change adoption	0.49	0.15	.29**
Medicaid census	-0.57	0.41	.12
For-profit vs. non-profit [a]	0.81	1.15	.08
Government vs. non-profit [a]	0.48	1.60	.03
Workforce racial composition	-0.21	1.47	.01

Note. Data were missing for 29 participants ($N = 118$). For the overall model $R^2 = .19$, $F = 4.24$.
[a] The profit status variable was transformed into a dichotomous categorical variable in order to run the regression analysis. Two dummy variables were created using non-profit status as the baseline comparison group.
* $p < .05$, ** $p < .01$

Aim 4

The fourth aim was to examine how external factors such as geographic location and community racial composition influence WD management practices. The data used for geographic location were derived from the 2000 Rural Urban Commuting Area (RUCA) codes,

and community racial composition data was taken from U.S. Census data. The information regarding these variables is described in the Sample Characteristics section (page 71). A regression analysis was conducted to determine if the nursing home external factors would predict diversity management practices.

Regression Analyses. The external factors (geographic location and community racial composition) were regressed onto the diversity management scale total score. Prior to running the regression analysis, three dummy codes were created for the four categories of RUCA codes to create dichotomous categorical variables. Urban focused was used as the baseline comparison group when creating the dummy codes, since it was predicted that urban focused facilities would have higher diversity management practices. Preliminary analyses were conducted to check for outliers and violations of assumptions of normality, linearity, multicollinearity, homoscedasticity, and independence of residuals. Data screening led to the elimination of the same two cases that were eliminated in the previous analysis. As discussed, above these data appear to have violated the assumption of normality.

The regression results indicated the model was not a significant predictor of diversity management practices, F (4, 136) = .826, p = .51; the total variance explained by the model was only 2.4%. None of the independent variables were statistically significant. The external factors did not make a significant contribution to the model. Hypotheses four and five were not supported, as the nursing home external factors did not predict diversity management practices. A summary of the regression coefficients is presented in Table 29 (below).

Table 29

Standard Multiple Regression Analysis: Final Model Coefficients for External Predictors of Diversity Management Practices

Variables	*B*	*SE B*	β [b]
Constant	32.63	1.33	
Large rural city vs. urban focused[a]	0.28	1.29	.02
Small rural town vs. urban focused[a]	1.39	1.29	.10
Isolated small rural town vs. urban focused[a]	-1.55	1.34	-.10
Community racial composition	0.002	0.02	.008

Note. Data were missing for 27 participants (N = 141; Although there were diversity management scale scores for 144 participants, two outliers were removed from analysis and one facility did not have a valid RUCA code). For the overall model R^2 = .02, F = 0.83

[a] The RUCA Code variable was transformed into a dichotomous categorical variable in order to run the regression analysis. Three dummy variables were created using urban focused category as the baseline comparison group.

[b] None of the external variables were significant predictors of diversity management practices

Additional Exploratory Analyses

Additional analyses were conducted to further investigate potential relationships between various variables collected in the survey to one another. The results that were found to be significant are presented below.

A Pearson product-moment correlation was run to determine the relationship between the total scores on the diversity management scale, the R-T-D Inventory, and the culture change adoption scale. There was a medium, positive correlation between the scores on the diversity management scale and the R-T-D Inventory, r = .41, n = 141, p < .001, with higher diversity management practices associated with more positive attitudes toward diversity. There was also a significant positive relationship between scores on the culture change adoption scale and the diversity management scale, r = .21, n = 139, p < .05, with facilities with higher levels of culture change adoption also having higher diversity management scores. Additionally, when the culture

change adoption scores were compared to the other variables, it was found to have a small, positive correlation with the R-T-D Inventory, $r = .19$, $n = 146$, $p < .05$.

A one-way between groups analysis of variance (ANOVA) was conducted to explore the relationship between the diversity management scores and profit status. The results revealed a significant difference at the $p < .05$ level in diversity management scores for the three profit-status categories: F (2, 141) = 4.6, $p = .01$, $\eta^2 = .06$. Post-hoc comparisons using Tukey HSD test indicated that the mean diversity management score among for-profit facilities ($M = 3.36$, $SD = 0.48$) was significantly higher than non-profit facilities ($M = 3.03$, $SD = 0.66$). Government owned facilities ($M = 3.16$, $SD = 0.71$) did not differ significantly from either for-profit or non-profit facilities.

Several analyses were conducted to assess the relationship between the racial composition variables and other survey items. The results revealed a strong significant correlation between resident racial composition and workforce racial composition, $r = .68$, $n = 124$, $p < .001$; as the percentage of White residents increased so did the percentage of Whites in the facility. There was also a significant correlation between resident racial composition and community racial composition, $r = .65$, $n = 126$, $p < .001$, with the percentage of White residents increasing as the percentage of White community residents increasing. The percentage of Whites in the facility also increased as the community grew less diversity ($r = .71$, $n = 128$, $p < .001$). Culture change adoption was also significantly correlated with the racial composition of unit manager and the residents, $r = .21$, $n = 101$, $p < .05$ and $r = .24$, $n = 124$, $p < .01$, respectively. The degree of culture change adoption increased as the percentage of White unit managers and residents in the facility increased.

A second ANOVA was conducted to explore the relationship between the RUCA categories and workforce racial composition. There was a statistically significant difference in the workforce racial composition by geographic location, F (3, 125) = 5.0, p = .001 η^2 = .12. Post-hoc comparisons using Tukey HSD test indicated that facilities in urban areas (M = 37.5, SD = 28.6) had a lower percentage of White employees than those in large rural cities (M = 64.3, SD = 32.2). Moreover there was also a statically significant result for community racial composition by geographic location, F (3, 146) = 2.7, p = .05 η^2 = .05, with facilities in urban areas (M = 61.0, SD = 24.7) having a lower percentage of White employees than those in large rural cities (M = 74.3, SD = 22.0).

Exploratory regression analyses were conducted to determine which survey variables best predicted workforce diversity management principles and practices. In addition to the external and internal factors, the following variables were included in the model: race, gender, years of experience (in current position, facility, and long-term care), R-T-D Inventory scores, Medicare census, availability of translation services, as well as the racial composition of the nursing leadership (unit managers and RNs), unit managers only, and residents. Given the exploratory nature of this analysis, multiple regression using backward deletion was conducted resulting in the elimination of least predictive variables from each model. The same violations and outliers were identified in this model as previously discussed in the sections above. In Step 1 of the model, all the variables predicted 55.1% of the variance, F (23, 59) = 3.1 p < .001. However, the backward multiple regression results indicated a final model of six variables that significantly predicted workforce diversity management practices, F (7, 75) = 9.3, p < .001. The model accounted for 46.6% of the variance in diversity management practices. The facilities that were a part of a chain and offered translation services were more likely to have higher diversity

management scores. Likewise, leaders who were male, had more positive attitudes and perceptions of diversity (i.e. higher R-T-D scores), and those who had more experience in long-term care had higher diversity management scores. On the other hand, as the Medicaid census and years of experience in the leaders' current position increased, the diversity management scores decreased. A summary of the coefficients from the final model of the backward regression model is listed in Table 30.

Table 30

Backward Multiple Regression Analysis: Final Model Coefficients for Exploratory Predictors of Diversity Management Practices

Variables	*B*	*SE B*	*β*
Constant	30.68	2.20	
Chain affiliation	-3.28	1.09	-.28**
Medicaid census	-1.00	0.42	-.21**
R-T-D total score	0.29	0.05	.49***
Translation services available	-3.07	1.05	-.27**
Gender	-2.57	1.02	.23*
Total years on current job	-0.13	0.06	-.23*
Total years in long-term care	0.12	0.07	.21†

Note. Data were missing for 87 participants ($N = 83$). For the final step in the model $R^2 = .46$, $\Delta R^2 = -.02$, $F = 9.28$, $\Delta F = 2.11$.
† $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

CHAPTER 5

DISCUSSION

Discussion of Findings

There is an extensive amount of literature on workforce diversity (WD) in multinational corporations, yet this research is unlikely to be generalizable to smaller organizations, such as nursing homes, with limited resources. This study sought to better understand WD principles and practices in nursing homes. The following discussion expounds on the study results and compares the findings to existing literature.

Overall, the findings suggest the nursing home leaders had a limited understanding of WD. Federal and state workforce discrimination policies and laws heavily influenced the leaders' perceptions of diversity management. The practices most closely associated with diversity involved recruitment, customer service, and communication/interpersonal skills. Diversity management appears to manifest through informal actions by the facility leadership, as few leaders reported having written diversity programs or policies. The level of diversity management among the sample was dependent upon organizational factors within the facility. The external community did not appear to influence diversity management within the facility.

Aim 1 Discussion

Nursing homes leaders tended to have a narrow definition of WD, which lent support for the first hypothesis. Very few nursing home leaders had a clear understanding of the difference between WD and EEO/AA policies. Moreover, nursing home leaders' understanding of WD seemed to be even less than U.S. employees in other disciplines (Carrell & Mann, 1993; Carrell et al., 2006; Muller & Haas 1994). Thus, it appears nursing home leaders lag behind in their

general knowledge regarding WD, which is unfortunate given the dire need to improve WD and race relations in nursing home settings. However, nursing home leaders included concepts such as culture, race, age, gender, and national origin in the meaning of diversity, which is in accordance with the literature (Carrell & Mann, 1993; Carrell et al., 2006; Thomas, 1990; Vinson, 2011; Weech-Maldonado et al., 2002). In line with previous studies, the results revealed the terms included in EEO/AA definitions were ranked highest in yes responses. Similarly, sexual orientation and geographic region were among the lowest to receive yes responses in this sample, consistent with other studies (Carrell & Mann, 1993; Carrell et al., 2006). The number of terms associated with diversity in the current study was 12, in comparison to 10 or less in previous research. These results suggest an evolving definition of diversity that includes a number of characteristics (Carrell & Mann, 1993; Carrell et al., 2006).

Regarding the leaders' perceptions and attitudes toward diversity, there was a nearly even division between those who had positive and those who had neutral feelings toward WD. Of the entire sample, only one leader had a negative view toward diversity. These results mirror the original study on the development of the R-T-D Inventory (De Meuse & Hostager, 2001). Overall, the high scores in the judgment dimension suggest, theoretically, nursing home leaders perceive WD to be positive and valuable. Additionally, their verbal and nonverbal actions in response to diversity tend to be positive. However, the leaders were not optimistic about the outcomes of diversity, nor were they convinced WD would influence them in a positive manner. It is possible nursing home leaders did not engage in as many WD practices because they did not see the benefits of making additional efforts to improve WD in their facility. The R-T-D Inventory also appears to be a good predictor of diversity management principles and practices,

These results offer additional empirical evidence that leaders' values and attitudes play a critical role in implementing diversity strategies.

There were two exploratory variables included in the survey: availability of translation services and experiences with racial discrimination. The majority of nursing homes offered translation services to residents with limited English proficiency (LEP). The type of translation service varied, and most facilities offered multiple services. This sample of leaders reported fewer trained medical translators on staff than previous studies (Davis & Whitman, 2008; Whitman & Davis, 2008; Whitman & Davis, 2009; Whitman & Valpuesta, 2010). This appears to be the first study to ask leaders about their experiences with discrimination. The leaders' responses were inconsistent with the direct care workers' responses in previous studies, as very few leaders reported experiencing racial discrimination on the job. It is possible the discrimination experiences were limited because the majority of the leaders were White, and they may be less likely to experience discrimination than minorities. Additionally, studies indicated the sources of racial discrimination include residents, family members, and employees (Berdes & Eckert, 2001; Mercer et al., 1993); however, leaders may have more interactions with employees and fewer interactions with residents and their family members (Vinson, 2011).

Aim 2 Discussion

When examining the individual items on the diversity management scale, the results revealed a large percentage of leaders reported that employee satisfaction data was evaluated and compared among racial groups. These results were inconsistent with the previous study in which the same item was asked of senior leadership staff in hospitals. The same was also true for the item that asked if the minority employees with potential for promotion or identified and supported. Also, the low percentage of physicians participating in diversity training in this study

was comparable to the early study (Weech-Maldonado et al. 2002). The facilities were more likely to take steps to improve the turnover ratios when they varied by race, as opposed to when the racial groups at each organizational level varied by race. This suggest that although the facilities may be aware of the racial disparities that exist across the organization structure, very little is done to rectify it.

Recruitment, customer services, and communication/interpersonal skills were the most frequently reported activities associated with diversity. The least frequent activities associated with diversity in this study were career management and language training. While the least frequent activities are the same as the previous longitudinal study by Carrell and colleagues (2006), the top three highest activities were different. Recruitment, selection and awareness training were previously reported to be the top three activities. However, given the leaders responses on the diversity management scale regarding diversity training, interviewing, as well as comparing racial data across the organization and service area, it is not surprising these leaders reported less involvement with these activities. The results also suggest WD principles and practices may be embedded into activities related to CMS requirements rather than stand-alone initiatives. Overall, the results indicate there are a number of activities within the organization in which diversity is integrated into the main objectives. Moreover, the results imply that leaders' are potentially aware of the importance of the diversity for retaining employees, providing quality care for their consumers (i.e. the residents), and facilitating effective communication between individuals within the facility. However, there may be missed opportunities to provide/include diversity in the trainings that are already in place, such as the annual in-service education requirements (CMS, 2007).

The results of the sources of diversity item were consistent with previous research (Carrell & Mann, 1993; Carrell et al., 2006). Interestingly, a very small number of facilities had EEO/AA departments. Although studies indicate the nursing staff are more likely to experience the negative consequences of a non-diverse workforce (Aries, 2004; Berdes & Eckert, 2001; Foner, 1995), the nursing staff represented in this study appeared to be less likely to initiate diversity policies, programs or discussion. Furthermore, while issues of diversity may be salient to nursing home leaders, these issues do not seem to be addressed outside of human resources or the leadership team. The results regarding written diversity policies or programs were comparable to the previous literature (Carrell & Mann, 1993; Carrell et al., 2006); however, nursing home leaders in this study reported a slightly higher percentage of written policies that include the concept of diversity than previous studies. Nonetheless, only one in five policies addressed the concept of diversity beyond the concept of EEO/AA. When the leaders elaborated on their perceptions of what their policies, few leaders provided explanations to suggested any real difference between the their policies and EEO/AA. Thus, these results further support the hypothesis that nursing homes leaders have narrow definition of WD.

Aim 3 Discussion

The results of the first regression analysis partially support the second and third hypotheses. While the regression model revealed that the internal factors significantly predicated diversity management scores. An analysis of the individual internal factors revealed that culture change adoption and chain affiliation were the only organizational level variables that significantly predicted diversity management. The results are consistent with the literature that posits organizational innovation strategies improve WD (Richard et al., 2003). Moreover, previous research by the current author, suggests nursing home leaders believe culture change

can improve WD because it can increase communication, provide direct care workers with more autonomy, and decentralize organizational hierarchies. Furthermore, although WD and culture change adoption are two distinct terms with different goals, nursing home leaders have previously reported the terms are synonymous (Vinson, 2011).

Remarkably, profit status was an internal factors that did not significant predict diversity management in any of the regression analyses, despite previous research suggesting that non-profit facilities may be more poised to implement diversity management strategies (Kemper et al., 2010; Sullivan Commission, 2004). In fact, the for-profit nursing homes had significantly higher diversity management scores than non-profit facilities. It is possible that these for-profit facilities have additional resources to invest in innovative initiatives to promote diversity. Given that for-profit nursing homes tend to have more racially diverse resident populations (Davis et al., 2014), these results could also suggest that the these non-profit facilities are responded to the diversity needs of their population by increase their WD policies and practices. As will be discussed in detail below, it is possible that the sample size was not large enough to detect significant differences with these variables.

Aim 4 & Exploratory Analysis Discussion

Although the aforementioned studies have previously found associations between perceptions of diversity management and racial composition of the facility and the community (Brief, 2005; Pugh et al., 2008), the current studied did not find any significant results using racial composition. Thus, the final hypothesis that nursing home external factors would predict diversity management practices was not supported. However, exploratory analyses revealed that community racial diversity was positively associated with resident racial diversity, which is consistent with previous research (Davis et al., 2014; Smith et al., 2007, 2008). Moreover, racial

composition was found to vary based on geographic location with urban focused facilities having more racially diverse staff and community members than large rural cities.

Medicaid census was also found to be a predictor of diversity management when additional exploratory analyses were conducted. A number of studies have shown that an increase in Medicaid census is associated with negative outcomes, such as decreased quality of care, staff retention, financial performance, and culture competency (Castle, 2001; Nyman, 1988; Zimmerman et al., 2002; Chisholm et al., 2013; Mor et al., 2004; Weech-Maldonado et al. 2012). Similarly, the results of this study also suggest that an increase in Medicaid census leads to negative outcomes regarding diversity management. The finding that chain affiliation is a significant predictor of diversity management also supports the premise that innovative strategies may improve diversity (Castle, 2001). As previously mentioned research suggests that chain facilities may have more resources to tap from in order pilot various initiatives. Moreover, these facilities may have more resources for recruitment and retention, diversity training, and staff time and resources to devote to initiating diversity programs and policies (Banaszak-Holl et al., 2002).

Limitations

There were inherent limitations to this study. A major limitation was the small sample size, which resulted in lower statistical power and higher chances of Type II error. Although some of the analyses conducted resulted in statistical significance, it is likely that a large proportion of the variables did not achieve adequate power to reach significance. Additionally, several of the analyses resulted in small effect sizes; this was likely the result of having less power and a small sample size. It is possible that the proposed regression models did not reach the desired significance level because the internal and external variables used in this study do not

influence diversity management within the sample. However, there is a greater chance the results did not reveal significant relationships between all the predictors and diversity management because the sample was too small to provide enough statistical power to demonstrate any significant differences. The sample appeared to be homogenous in terms of the demographic variables (i.e. race, position, and country of origin) and the leaders' responses appeared to be similarly across the four states. Perhaps, a larger sample size would create a more heterogeneous sample that would yield more significant results. The sample size limitation also influences the generalizability of the survey results. Given the assumptions of normality were violated, the results of this study cannot be generalized beyond the current sample. This violation is likely due to the small sample size, and it is possible the data would be normally distributed if the desired sample size had been obtained.

The use of survey methodology may also be another limitation. First, the information provided was based on self-report. Thus, the responses may have been influence by social desirability, meaning the reported responses may have been different from the actual accounts. However, given the anonymity of the survey, it is likely the participant responded in a truthful manner. Moreover, the leaders tended to report both positive and negative responses to the items related to racial discrimination and diversity, which would further suggest that the leaders were not fabricating responses in order to present in a more positive manner. Second, there were missing data for many of the variables collected in the survey, as well as several of the variables requiring zip codes for calculation. However, missing data was expected, as participants frequently overlook or decline to respond to items when completing surveys (Dillman et al., 2009). The items that were most commonly missing were the racial composition items perhaps because the information needed to complete these items may not have been readily available at

the time the leaders responded to the survey. Otherwise, there did not appear to be patterns of response bias in the missing data.

Third, it is possible that there may be differences in responses based on the survey type (i.e. paper vs. online) because the individuals who completed the paper survey could answer as many or as few questions as they desired. However, some of the online participants were required to respond to items before they could move forward. Finally, research suggests there is a downward trend in online and paper survey response rates due to the increase in unsolicited "junk mail" and the ease of conducting large-scale research studies (Sax, Gilmartin, Bryant, & 2003). Individuals may receive as many as 39 unsolicited emails per day, which may lead them to develop strategies to address them. Such strategies include, using filtering programs, deleting all unsolicited emails, or only addresses emails that are relevant or of interests to the individual (Sax, et al., 2003; Sheehan, 2001). Pre- and post-survey contact has been associated with an increase in response rates, especially for online studies (Cook, Heath, & Thompson, 2000; Sheehan, 2001).

Another limitation had to do with the variables computed for the analyses. The culture change adoption scale did not have strong reliability. Although the diversity management scale had adequate reliability, the items made several assumptions regarding the facilities' organizational practices. For example, one item inquired about the content and frequency of diversity training under the assumption that the facility provides such training. Additionally, given that 2010 Census data was used to compute the community racial composition of facilities operating from the beginning of this research project in 2012 through its' conclusion in 2014, it is possible that the zip codes used misclassify the actual racial composition existing in the year the survey was completed. Moreover, the nursing home compare data was collected from the

website at the onset of the research study in 2012. Thus, the data from this website may not have been an accurate representation of the facility at the time the leaders responded to the survey. The data also only represent the opinions and perceptions of one leader in the facility, and the leaders in this survey are primarily nursing home administrators. It is possible that the administrative leaders may have differing opinions and perceptions than the nursing staff leaders. Moreover, senior level leaders, such as chief executive officers, may also have opposing views of the concepts assessed in the survey.

Implications

This study has important implications for long-term care practice and policy development. First, the study was novel, in that no other studies have examined workforce diversity perceptions or described specific diversity practices and programs in nursing home settings. Another implication of this research is that leaders need more education on how WD and diversity management are defined. In the current study, the majority of leaders defined WD in a narrow manner that mainly focused on EEO/AA and does not go beyond the idea of protecting vulnerable groups in the workplace. As more consideration is given to diversity management, it will become imperative for nursing homes to distinguish between EEO/AA guidelines and formal WD management strategies. While diversity management is likely to counteract EEO claims, EEO policies will not address the underlying causes of any prejudice and discrimination that exists, nor will they help diverse groups to feel valued for their different perspectives. This study might inform the Equal Employment Opportunity Commission (EEOC) on ways they might improve upon the definition of their role, as well as what their guidelines do and do not cover in terms of WD. This additional clarification may illustrate to leaders that diversity management requires efforts above and beyond the compliance laws. Additionally,

federal and state policy makers might be interested in how to modify CMS nursing home guidelines to include diversity training requirements.

Although any changes in CMS requirements and reimbursements may be aspirational in intent, it is possible that changes to the current structure could bring about improvements in WD. The current study suggests that higher Medicaid rates may be associated with lower diversity management practices. Perhaps, facilities with higher Medicaid census lack the resources to implement WD strategies, and factors such as quality, turnover, financial performance, and cultural competency mediate the relationship between Medicaid census and WD management. Researchers have made the argument for increasing Medicaid reimbursements to improve quality of care in these low performing facilities. It is possible these facilities have poorer quality because they lack the financial resources to provide adequate quality of care. It appears the loss of revenues from Medicaid reimbursements is never regained and comes at the cost of quality of care (Chisholm et al., 2013). One alternative solution would be to increase Medicaid payments to facilities with higher Medicaid rates or "low resource facilities" so facilities would have revenue to invest in other areas, such as improving diversity management. While workforce racial composition did not predict diversity management in this study, there may be some empirical evidence for an increase in Medicaid reimbursement rates to improve diversity (and subsequently diversity management) and access to care in facilities with moderate segregations levels (Davis et al., 2014). Yet another aspirational CMS change might be to initiate pay-per-performance systems in which diversity management is used as an indicator of quality. Given the research suggesting some, but not all, hospitals in diverse communities use cultural competency to its advantage in competitive markets, an increase in government involvement may be needed to create widespread improvements in diversity management. For example, CMS could mandate

interpretation services, diversity training, and/or written diversity management policies as national requirements (Weech-Maldonado et al., 2012). The reporting of cultural competency measures in standardized national reporting systems and metrics may be warranted, especially if future studies can provide empirical evidence to demonstrate that diversity management improves patient satisfaction and health outcomes.

This study makes a case for the need to increase attention to diversity management in nursing homes and interventions to effectively manage diversity. The results suggest there may be good predictors of diversity management that facilities can assess and utilize to improve WD. The study also has important implications for nursing home owners regarding how to improve leaders' ability to promote WD. The results can inform nursing home owners about how their diversity programs, or lack thereof, are actually perceived by their administrative staff. As discussed above, there may be opportunities to include topics of diversity into training that is already being provided through orientations, in-services, and required CMS continuing education.

This research may also help nursing home leaders understand the recruitment and retention strategies used to attract employees, and where they can make room for improvements. The R-T-D Inventory appears to be a reliable measure of nursing home leaders' attitudes and perceptions of diversity. This measure might be a useful instrument for the recruitment and selection of leaders who value diversity. It might also identify common areas that need improvement. The measure also appears to have implications for how to customize WD training to include education regarding how WD may benefit the organization. The subscale scores on the R-T-D Inventory can illustrate potential sources of WD resistance and support, which will inform leaders regarding interventions strategies to implement or areas to facilitate WD

discussions. The study could also identify specific areas for diversity training programs with measurable outcomes to promote an inclusive culture where diversity is valued and the nursing home benefits from the various perspectives.

The diversity management scale also appears to be a reliable measure of diversity principles and practices that are being implemented in nursing homes. This measure may also be used as a self-assessment tool to identify indicators for WD growth. The results suggests there are a number of individuals/departments who can and do initiate WD programs and discussions, and perhaps this is evidence for more organizational wide efforts to address diversity from a macro level where all employees are responsible for speaking up on issues of diversity.

Conclusion

This research employed survey methodology to explore workforce diversity management among nursing homes in the Deep South. Surveys from approximately 150 nursing home leaders were collected and analyzed for this study. The leaders were responded to survey items related to their understanding of diversity and diversity management, as well as specific organizational and demographic characteristics that influence diversity management perceptions and practices. The results revealed that managers had positive to neutral attitudes toward diversity and they tended to narrowly define diversity in terms of EEO/AA programs and requirements. Chain affiliation and increasing levels of culture change adoption appeared to be good predictors of workforce diversity management. There was also some evidence to suggest that Medicaid census, diversity attitudes and perceptions, gender, availability of translation services, and years of experience predicted diversity management. The results of this study are relevant to the long-term care and management literature, and study results are consistent with several studies related to WD. The

results of this research will aid in developing diversity promotion strategies to improve work-life in nursing home settings.

Future Research

Future studies can replicate this research to increase the response rate or to include additional states outside of the Deep South. Potential methods to improve the response rate may include contacting each leader by phone prior to mailing out the survey and mailing the survey within the same day the leader agrees to complete the survey. Multiple follow-up reminders may also increase the response rate. Furthermore, monetary incentives or endorsements of the survey from credible sources may also increase the likelihood of completion. Expanding the survey may also improve the generalizability of the results and allow for comparisons across geographic regions. Moreover, the predictor variables would need to be further examined to develop benchmarking in which best-practices could be identified in high performing nursing homes. Finally, expanding this research to Community Living Centers (CLCs) in the VA (Veteran Affairs Administration) would also provide a unique opportunity to examine the proposed hypotheses. Unlike many of the private nursing homes in this study, the VA has resources to promote a diverse and inclusive workforce through internal organizations such as the Office of Diversity Inclusion. Thus, future studies could examine how the perceptions of diversity management among CLC leaders compare to the community nursing homes in this sample.

Future research can also be conducted to explore the use of the culture change adoption and diversity management scales that were developed as brief assessment measures for this study. Further studies can further investigate the validity and reliability of these scales for use in this population. Additionally, when researching diversity management and culture change, the term innovation was used when discussing the implementation of diversity management and

culture change strategies within organizations. Thus, future research might also include the use of innovation measures to determine if innovation might serve as a mediator or moderator between the external and internal organizational factors and diversity management principles and practices. Additional research might also be conducted to explore how diversity management perceptions influence long-term care quality indicators such as falls, pain, antipsychotic medication use, and depression. Additionally empirical evidence is needed to explain the relationship between diversity management and quality of care. Such evidence could serve as a rationale to advocate for the use Medicare reimbursements to invest in diversity management.

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LIST OF APPENDICES

APPENDIX A: Study Survey Items

SECTION A: RESEARCH CONSENT

I have read this consent form. The study has been explained to me. I understand what I will be asked to do. I freely agree to take part in it. I will keep a copy of the consent form.

❑ **I agree** to participate in this study and allow my responses to be used for this research project.

❑ **I do not agree** to participate in this study.

SECTION B: DEMOGRAPHICS

1. **Please indicate your current position:**
   ❑ Administrator ❑ Assistant Administrator ❑ Director of Nursing

2. **Age:** _____

3. **Gender:**
   ❑ Male ❑ Female

4. **Ethnicity:**
   ❑ Hispanic ❑ Non Hispanic

   Race:
   ❑ African American ❑ White (not of Hispanic origin) ❑ Hispanic
   ❑ African/Caribbean ❑ Asian or Pacific Islander ❑ American Indian/Alaska Native
   ❑ Other/Multiracial (indicate each applicable race) _____

5. **What is your country of origin?** _____

6. **Last Education Completed:**
   ❑ Doctoral Degree ❑ Masters Degree ❑ Bachelors Degree
   ❑ Associates Degree ❑ Some College ❑ High School
   ❑ Technical ❑ Trade ❑ GED
   ❑ Other _____

7. **Please indicate the discipline in which you received formal training (i.e. health, nursing, business, law, social work, etc.).** _____

8. **How long have you worked at your facility?**
   _____ Years & _____Months

9. **How long have you worked in your current job title (including both your time at your current facility and your time at other facilities)?**
   _____ Years & _____Months

10. **How long have you worked in long-term care (including the time worked under other job titles)?**
    _____ Years & _____Months

THANK YOU FOR COMPLETING SECTION B. PLEASE CONTINUE ON TO SECTION C.

SECTION C: ORGANIZATIONAL CHARACTERISTICS

11. Approximately what is the Medicaid census at your nursing home?

- ❑ 0-20%
- ❑ 21-40%
- ❑ 41-60%
- ❑ 61-80%
- ❑ 81-100%

12. Approximately what is the Medicare census at your nursing home?

- ❑ 0-20%
- ❑ 21-40%
- ❑ 41-60%
- ❑ 61-80%
- ❑ 81-100%

13. Are translation services readily available for residents and family members to whom English is a second language?

- ❑ Yes

  Please identify the type (select all that apply):

  - ❑ Bilingual Employees
  - ❑ Full-time trained medical translator
  - ❑ Language Banks
- ❑ No

14. Please indicate the racial/ethnic group of your facility's Administrator and Director of Nursing.

Race	Administrator	Director of Nursing
African American		
White (not of Hispanic origin)		
Hispanic		
Asian or Pacific Islander		
American Indian/Alaskan Native		
African/Caribbean		
Other/Multiracial (please specify)		

15. Please indicate the number of individuals that fall into each of the following racial/ethnic groups in your nursing home. If none, please indicate "0."
Note: It may be helpful to refer to your employee time sheet or the Equal Employment Opportunity Report (EEO-1) filled out by the human resources department of your nursing home.

Race	Direct Care Workers	RNs	LPNs	Unit/Mid-Level Managers
African American				
White (not of Hispanic origin)				
Hispanic				
Asian or Pacific Islander				
American Indian/Alaskan Native				
African/Caribbean				
Other/Multiracial				
TOTALS (optional)				

SECTION C CONTINUED: ORGANIZATIONAL CHARACTERISTICS

16. Please indicate the number of residents that fall into each of the following racial/ethnic groups in your nursing home. If none, please indicate "0."

Race	Residents
African American	
White (not of Hispanic origin)	
Hispanic	
Asian or Pacific Islander	
American Indian/Alaskan Native	
African/Caribbean	
Other/Multiracial	
TOTALS (optional)	

DIRECTIONS: PLEASE INDICATE HOW OFTEN THE FOLLOWING STATEMENTS OCCUR IN YOUR FACILITY.

17. Waking times/bed times are chosen by the residents.

❑ Always ❑ Often ❑ Sometimes ❑ Occasionally ❑ Never

18. Please indicate the percent of residents who live in households that are self-contained with full kitchen, living room and dining room for the household or unit.

❑ 0% ❑ 1-20% ❑ 21-40% ❑ 41-60% ❑ 61-80% ❑ 81-100%

19. A kitchenette or kitchen area with at least a refrigerator and stove is available to families, residents, and staff where cooking and baking are welcomed.

❑ Always ❑ Often ❑ Sometimes ❑ Occasionally ❑ Never

20. Learning Circles, or their equivalent, are used regularly in staff and resident meetings in order to give each person the opportunity to share their opinion/ideas.
*****Note: A Learning Circle is a group of individuals with a common interest who meet regularly to learn from each other, and others, about a self-identified topic and in a format the group has decided upon. Learning Circles are intended to lead to action and change.***

❑ Always ❑ Often ❑ Sometimes ❑ Occasionally ❑ Never

21. Direct care workers consistently work with the same residents or the same group of residents (with no rotation).

❑ Always ❑ Often ❑ Sometimes ❑ Occasionally ❑ Never

22. Please indicate the direct care worker turnover rate for your facility.

❑ 0-19% ❑ 20-39% ❑ 40-59% ❑ 60-79% ❑ 80-99% ❑ 100+%

THANK YOU FOR COMPLETING SECTION C. PLEASE CONTINUE ON TO SECTION D.

SECTION D: DIVERSITY & ITS MANAGEMENT

23. DIRECTIONS: Check all the words below that you frequently associate with workplace diversity.
*****Note: Please give your honest opinions and remember all your answers are confidential.***

- ❑ Compassionate
- ❑ Stress
- ❑ Fight
- ❑ Stubbornness
- ❑ Excited
- ❑ Fear
- ❑ Proud
- ❑ Justified
- ❑ Rivalry
- ❑ Unjustified
- ❑ Asset
- ❑ Sacrifice
- ❑ Pressure
- ❑ Friendly
- ❑ Patronize
- ❑ Unfriendly
- ❑ Proper
- ❑ Apprehensive
- ❑ Ethical
- ❑ Anger
- ❑ Support
- ❑ Liability
- ❑ Disorder
- ❑ Sensible
- ❑ Clashes
- ❑ Cooperate
- ❑ Confused
- ❑ Harmony
- ❑ Expensive
- ❑ Unprofitable
- ❑ Collaborate
- ❑ Understand
- ❑ Merit
- ❑ Profitable
- ❑ Sleeplessness
- ❑ Opportunity
- ❑ Resentment
- ❑ Wisdom
- ❑ Bad
- ❑ Innovation
- ❑ Resist
- ❑ Grateful
- ❑ Unfair
- ❑ Happy
- ❑ Frustration
- ❑ Team-building
- ❑ Rewarding
- ❑ Good
- ❑ Immoral
- ❑ Worthless
- ❑ Disagree
- ❑ Regulations
- ❑ Advancement
- ❑ Unity
- ❑ Bureaucratic
- ❑ Discovery
- ❑ Useless
- ❑ Listen
- ❑ Insecurity
- ❑ Progress
- ❑ Blame
- ❑ Turnover
- ❑ Participate
- ❑ Hopeful
- ❑ Fair
- ❑ Unnatural
- ❑ Withdrawal
- ❑ Enthusiastic
- ❑ Useful
- ❑ Enrichment

24. Please indicate whether you believe the following characteristics are included in the concept of "diversity."

Characteristic	Yes	No	Uncertain
1. Race/Color			
2. Gender			
3. Age			
4. Culture/Ethnicity			
5. National Origin			
6. Religion			
7. Language Differences			
8. Handicap/Physical Ability			
9. Regional/Geographic Location			
10. Sexual Orientation			
11. Education			
12. Income			
Other, please specify _____			

SECTION D CONTINUED: DIVERSITY & ITS MANAGEMENT

DIRECTIONS: PLEASE INDICATE WHETHER YOU BELIEVE THE FOLLOWING STATEMENTS DESCRIBE YOUR FACILITY.

25. The racial/ethnic demographics of the workforce are routinely compared to the racial/ethnic demographics of the service area.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

a. Corrective action is taken promptly when employee job offers or turnover ratios vary by race/ethnicity.

❑ Yes

❑ No

26. Racial/ethnic demographics of the workforce are routinely compared by level (executive, management, professional, and service).

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

a. Corrective action is taken promptly when the racial/ethnic composition of the workforce varies by level.

❑ Yes

❑ No

27. Employee satisfaction is routinely evaluated and compared among all racial/ethnic groups.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

28. Diversity training is designed in response to systematic assessment of the racial/ethnic diversity climate and culture.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

29. Diversity training is provided frequently.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

a. Please select which employees participate in the training (select all that apply)

- ❑ Non-clinical Staff
- ❑ Managers and Other Supervisors
- ❑ Nurses and Other Caregivers
- ❑ Executives
- ❑ Physicians

30. Racially/ethnically diverse employees with potential for advancement are systematically identified and supported.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

31. Prospective employees are interviewed by a team that is diverse by race/ethnicity.

❑ Strongly Agree ❑ Agree ❑ Neither Agree or Disagree ❑ Disagree ❑ Strongly Disagree

SECTION D CONTINUED: DIVERSITY & ITS MANAGEMENT

32. Formal mentoring programs are emphasized.

❑	❑	❑	❑	❑
Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

33. Management talks openly about issues of race/ethnicity.

❑	❑	❑	❑	❑
Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

34. Literacy, GED, English, or foreign language classes are offered at no charge to all employees.

❑	❑	❑	❑	❑
Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

35. On your current job, have you ever been discriminated against because of your race or ethnic origin? This could be from your employer, resident or resident's family.
*****Note: Please remember all your answers are confidential.***

- ❑ Yes
- ❑ No
- ❑ Uncertain

36. In your opinion, is WD substantially different from Equal Employment Opportunity/Affirmative Action (EEO/AA) programs in scope?
*****Note: EEO/AA programs are defined as formal or informal rules, policies, procedures, or regulations that encourage equality in employment and fight against discrimination toward job applicants or employees because of personal demographic characteristics.***

- ❑ Yes
- ❑ No
- ❑ Uncertain

If yes, please explain how WD is substantially different from EEO/AA in scope.

_____
_____
_____

37. Which activities are associated with diversity policies and programs within your organization? (Select all that apply)

- ❑ Recruitment
- ❑ Selection
- ❑ Sensitivity Training
- ❑ Language Training
- ❑ Customer Services
- ❑ Awareness Training
- ❑ Workshops on Issues
- ❑ Skills Enhancement/In-Service Education
- ❑ Career Management
- ❑ Communication/Interpersonal Skills
- ❑ Other _____

38. In your organization, who has initiated diversity policies, programs, or discussions? (Select all that apply)

- ❑ CEO/Corporate Officers
- ❑ Board of Directors
- ❑ Director of Nursing
- ❑ Nursing & Direct Care Staff
- ❑ Human Resources/Professional Development
- ❑ EEO/Affirmative Action departments
- ❑ Administrator
- ❑ Mid-Level Managers/Supervisors
- ❑ Other _____

39. Does your nursing home have a written policy or program that includes the concept of diversity?

❑ YES:

a. Does your policy address the concept of diversity beyond the concept of EEO/AA?
   ❑ Yes
   ❑ No

   If yes, Please explain:

   _____
   _____
   _____

❑ NO:

a. Are you aware of any new policies being implemented, in planning, or under discussion?
   ❑ Yes
   ❑ No

YOU HAVE COMPLETED THE SURVEY.

Thank you for taking the time to complete this survey! Your answers are greatly appreciated.

When you are done, please use the enclosed prepaid envelope to return the survey.

APPENDIX B: Telephone Script

1. Telephone Script – initial call for Principal Investigator, Latrice Vinson
   Hello (Mr. or Ms.) (Insert Name). My name is Latrice Vinson and I am a graduate student in clinical psychology at the University of Alabama. I am calling to introduce myself and invite you to participate in a research study that I am conducting for my doctoral dissertation. I am sending questionnaires to all nursing homes in the Deep South inquiring about workforce diversity principles and practices. The questionnaire includes 39 questions that will only take approximately 15 minutes to complete. In the next week you will receive an introduction letter and a consent form from me and my advisor, Dr. Lynn Snow. These documents will have more specific information about the study. I am offering the questionnaires in a paper form and internet form. Would you like to fill out a paper questionnaire or complete it online? (Allow response)

   If I needed to contact you again, would you prefer to be contacted by phone or email? (Allow response. If the administrator prefers to be contacted by email, get correct email address.)

   Thank you so much for your time.

2. Telephone Script – initial call for Research Assistants
   Hello (Mr. or Ms.) (Insert Name). My name is (Insert Name) and I am an undergraduate student in the psychology department at the University of Alabama. I am calling on behalf of Latrice Vinson, who is a clinical psychology graduate student here at the University. I am calling to introduce myself and invite you to participate in a research study that Latrice is conducting for her doctoral dissertation. Latrice will be sending questionnaires to all nursing homes in the Deep South inquiring about workforce diversity principles and practices. The questionnaire includes 39 questions that will only take approximately 15 minutes to complete. In the next week you will receive an introduction letter and a consent form from Latrice and her advisor, Dr. Lynn Snow. These documents will have more specific information about the study. The questionnaire is being offered in a paper form and internet form. Would you like to fill out a paper questionnaire or complete it online? (Allow response)

   If we needed to contact you again, would you prefer to be contacted by phone or email? (Allow response. If the administrator prefers to be contacted by email, get correct email address.)

   Thank you so much for your time.

APPENDIX C: Survey Introduction Letter

ID # _____

College of Arts and Sciences

Department of Psychology

THE UNIVERSITY OF
ALABAMA
ARTS & SCIENCES

Dear Nursing Home Leader,

You are being invited to participate in a brief research survey of workforce diversity, entitled "An Exploration of Workforce Diversity Management Principles & Practices in Nursing Homes." The study will investigate nursing home leaders' perceptions of workforce diversity and diversity management principles and practices.

Enclosed you will find an informed consent document and a return envelope. You may also access the questionnaire at the following website: *http://tinyurl.com/wdsurvey2*. Please read the informed consent document. You may notice a questionnaire number listed above. This number will ONLY be used to match your responses to various facility characteristics that will be obtained from public data sources (i.e. Nursing Home Compare), as well as to let us know if you returned your survey so we do not have to send you reminders. Information that identifies you or your nursing home will be kept confidential and used only for the purposes of this study.

If you would like more information more about this study, please call 205-348-9973. Thank you very much for your time and consideration.

Sincerely,

Latrice D. Vinson, MA
Clinical Psychology Graduate Student

SURVEY INSTRUCTIONS

- Please read the consent form and check the appropriate box stating your participation.
  - *A nursing home administrator, assistant administrator, or director of nursing can complete this survey. If you chose not to participate, please consider sharing the survey with one of the aforementioned leaders in your facility.*
- Please answer the questions in this survey about the nursing home where you received this questionnaire. The time frame to keep in mind is the last 12 months.
- Please answer all questions to the best of your knowledge. The survey includes 39 questions that will *only take approximately 15 minutes to complete.*
- When you have completed this survey, please use the postage-paid envelope to return all sections. You may keep the consent form for your records.

SURVEY SECTIONS

348 Gordon Palmer
Box 870348
Tuscaloosa, Alabama 35487-0348
FAX (205) 348-8648
www.as.ua.edu/psychology

Appendix D: Informed Consent Document

UNIVERSITY OF ALABAMA
Informed Consent for a Research Study

You are being asked to take part in a research study. This study is called *An Exploration of Workforce Diversity Management Principles & Practices in Nursing Homes*. The study is being done by Latrice D. Vinson, MA, a doctoral student at the University of Alabama, and *A. Lynn Snow, PhD,* a University professor.

What is this study about?
This study is being done to better understand workforce diversity in nursing homes. Specifically, we want to learn more about nursing home leaders' perceptions of workforce diversity and diversity management principles and practices. This study will lead to a better understanding of specific issues related to diversity and what strategies can be used to promote diversity in the nursing home.

Why is this study important--What good will the results do?
This knowledge is important/useful because a better understanding about workforce diversity in nursing homes will help us improve work life for nursing home employees working in diverse groups. Additionally, improvements in diverse workgroup outcomes can directly impact the quality of care provided to the nursing home residents.

Why have I been asked to take part in this study?
You have been asked to participate in this study because you work in a leadership position at a nursing home.

How many people besides me will be in this study?
Approximately 1,100 nursing home leaders in Alabama, Georgia, Mississippi, and Tennessee will be asked to participate in this study.

What will I be asked to do in this study?
If you decide to be in this study, you will be asked to complete a survey about your perceptions of workforce diversity and diversity management. The survey includes 39 multiple choice and short answer questions. The survey can either be completed on paper (enclosed) or online at (http://tinyurl.com/wdsurvey). If you complete the survey online, please enter the identification number (found at the top of the introduction letter) in the space labeled "ID #" on the survey. The identification numbers are used by the researchers to keep track of the surveys that have been completed. You may receive a phone call from the researchers to remind you to complete the survey.

How much time will I spend being in this study?
The survey will take approximately 15 minutes to complete.

Will I be paid for being in this study?
You will not be compensated for being in this study, however, you will received a workforce diversity toolkit, which will include information and resources on how you can improve workforce diversity within your organization.

Will being in this study cost me anything?
There will be no cost to you except for your time in completing the survey.

Can the researcher take me out of this study?
Because you will complete this study at a location of your choosing, the researcher will not be able to remove you from the study. If you are completing the paper version of the survey, you must check the "I agree" box located at the top of page 2 on the survey in order for your survey responses to be included in the study. If you complete the study online, you must check the "I agree" box to continue the study.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 9-30-13
EXPIRATION DATE: 9-29-14

What are the benefits (good things) that may happen to me if I am in this study?
There are no direct benefits to you from being in this study.

What are the benefits to scientists or society?
This study will help scientists understand diversity in nursing homes and how it compares to other organizations. Nursing home leaders will also learn what kinds of changes can be made to improve diversity at work. Society will benefit from this study because the results can help improve work life for nursing home employees.

What are the risks (dangers or harm) to me if I am in this study?
There are no risks associated with participating in this study.

How will my confidentiality (privacy) be protected? What will happen to the information the study keeps on me?
Information identifying the participants will not be located on the survey. Each nursing home has an identification number, which is listed at the top of the introduction letter. If you choose to complete the online version of the survey, please enter the identification number in the appropriate place on the survey. This number allows us to track which surveys are returned to ensure that we do not attempt to make reminder phone calls to those who responded to the first mailing, as well as allowing the researchers to link the appropriate nursing home external and internal factors.

The survey responses will be downloaded from the online survey site. The data from the surveys returned in the mail will be entered into an electronic file. All survey data and the subject identification list will be stored on Latrice Vinson's university computer, which is password protected. The paper surveys will be stored separately in a locked file cabinet also in Latrice Vinson's office. Only co-investigators on this study will have access to the data, subject identification list, and paper surveys. The subject list and paper surveys will remain on file for a period of three years. At that time, they will be destroyed. The data from this survey will only be published in the aggregate with no identifying information included.

What are the alternatives to being in this study? Do I have other choices?
The alternative/other choice is not to participate.

What are my rights as a participant?
Taking part in this study is voluntary—it is your free choice. You may choose not to take part at all. If you start the study, you can stop at any time. Leaving the study will not result in any penalty or loss of any benefits you would otherwise receive.

The University of Alabama Institutional Review Board (IRB) is the committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Who do I call if I have questions or problems?
If you have questions about the study later on, please call Latrice Vinson at (205)348-9973 (email: ldvinson@crimson.ua.edu) or Dr. A. Lynn Snow at (205) 348-3655 (email: lsnow@as.ua.edu). If you have questions, concerns, or complaints about your rights as a participant in this research study, you may contact Ms. Tanta Myles, the Research Compliance Officer at the University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at http://osp.ua.edu/site/PRCO_Welcome.html or email us at participantoutreach@bama.ua.edu. After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask the investigator for a copy of it and mail it to the UA Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

APPENDIX E: Institutional Review Board Approval Document

September 30, 2013

Office for Research

Institutional Review Board for the Protection of Human Subjects

Latrice D. Vinson, MA, MPH
Department of Psychology
College of Arts & Sciences
The University of Alabama

THE UNIVERSITY OF ALABAMA RESEARCH

Re: IRB # 12-OR-329-R1 "An Exploration of Workforce Diversity Management Principles and Practices in Nursing Homes"

Dear Ms. Vinson:

The University of Alabama Institutional Review Board has granted approval for your renewal application.

Your renewal application has been given expedited approval according to 45 CFR part 46. You have also been granted the requested waiver of documentation of informed consent. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on September 29, 2014. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Study Closure Form.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

Carpantato T. Myles, MSM, CIM
Director & Research Compliance Officer
Office for Research Compliance
The University of Alabama

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