# MINORITY PERCEPTIONS REGARDING DIVERSITY MANAGEMENT INTERVENTIONS AND LEADERSHIP ADVANCEMENT IN HEALTH CARE INSURANCE ORGANIZATIONS

by

Chester N. Brown Jr.



A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Management in Organizational Leadership

University of Phoenix

The Dissertation Committee for Chester N. Brown Jr. certifies approval of the following dissertation:

MINORITY PERCEPTIONS REGARDING DIVERSITY MANAGEMENT INTERVENTIONS AND LEADERSHIP ADVANCEMENT IN HEALTH CARE INSURANCE ORGANIZATIONS

Committee:

Meryl P. Epstein, EdD, Chair

Brett Gordon, PhD, Committee Member

Bruce Laviolette, PhD, Committee Member

Meryl P. Epstein
Meryl P. Epstein

Brett Gordon

Bruce Laviolette
Bruce Laviolette

Hinrich Eylers, PhD
Vice Provost, Doctoral Studies
University of Phoenix

Date Approved: 1/31/2019

ABSTRACT

The lack of diversity in leadership is a national issue. In the health care industry, there is a disparity between the representation of minorities in leadership positions and the percentage of minority patients. Organizational practitioners needing solutions use diversity management interventions to address this issue. The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of the relationship of diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the United States. Affinity groups, mentoring, and training and development were the three diversity management interventions that were the focus of this study. A gap was identified through the literature search on the three diversity management interventions and their use in the health care insurance industry to address the lack of minority leadership advancement. Responses from 75 self-identified minorities in leadership positions in health care insurance organizations were collected utilizing the Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey to investigate the problem. Results were analyzed utilizing multiple regression analyses. The perceptions of two of the interventions, training and development programs followed by mentoring, had a significant relationship with the perception of leadership advancement. While only 9.3% of the study participants did not perceive there were in-house promotion opportunities, few study participants perceived their organizations recruit specific minority groups for team-leader roles. These findings are contributions to the on-going dialogue of diversity in leadership. Organizational practitioners may find value in understanding how to prioritize diversity management interventions.

# DEDICATION

I give thanks to the Lord, Jesus Christ, who makes all things possible. I dedicate this dissertation to my family, mentors, friends, committee members, and colleagues who have supported me along this lifelong learning journey. I am blessed to have parents who instilled in me the importance of education. To my wife, Lola Brown, I thank you for the many sacrifices made along the way. To my children Kyle Joshua Brown and Karis Joi Brown, I pass on the baton to also become life-long learners. I am blessed by the ongoing support of my brother, Daniel Ellis. I pay tribute to the memory of my brother, Eric Moten, gone too soon. To my friends and family who continually believed in me, I thank you for your prayers and continued encouragement.

ACKNOWLEDGMENTS

My success would not have been possible without the support and nurturing of the many teachers, professors, colleagues, peers, and acquaintances, I say thank you for the contributions to my personal and professional growth.

I would like to express my deepest appreciation to my committee. I am deeply indebted to Dr. Meryl Epstein who joined and led the committee during challenging portions of the journey after committee changes. The encouragement to stay the course and not lose momentum was priceless. I appreciate Dr. Bruce Laviolette's constructive feedback, which challenged me to really understand and value that full complexities of research. I thank Dr. Brett Gordon for contributions throughout the journey.

Special thanks to all of the faculty at the University of Phoenix who provided guidance throughout the beginning of this life-long journey. Thanks should also go to my academic counselor, Eric Klabe, for being responsive and guiding me through the academic administrative process.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

# Chapter 1

## Introduction

The lack of diversity in leadership is a national issue and is relevant to all business sectors, including the health care insurance industry. Investments in diversity and inclusion activities are at the forefront of organizational strategy. Events, regulations, and initiatives including the passage of the Civil Rights Act of 1964, Affirmative Action, and the Health People Initiative of 2010 have moved cultural competence and diversity management to the top of organizational agendas. Thus, organizations often support diversity activities in an attempt to manage biases, remove social isolation, and create ownership and responsibility for diversity (Kalev, Kelly, & Dobbin, 2006; Williams, Kilanski, & Muller, 2014).

While exact amounts are unknown, some industry experts have estimated that many organizations within the United States (US) spend as much as $8 billion annually on diversity training (Hansen, 2003; Jayne & Dipboye, 2004; Pitts, 2009). Many organizations claim to address diversity and include commitments to diversity in their mission statements (Futrell & Clemons, 2017; Gulati, Mikhail, Morgan, & Sittig, 2016; Versum Materials, 2018). They demonstrate such commitments by instituting a wide range of programs and initiatives to manage diversity, including implementation of affinity groups and mentoring programs focused on certain ethnic or racial groups, modification of hiring and recruitment practices to focus on underrepresented groups, and creation of training and development programs aimed at advancing minorities (Battle, Daniels, Hesselmann, & Thew, 2018; Carter, 2018; Castellucci, 2017; Hur & Strickland, 2015). However, these same organizations often fail to achieve diversity in management

and leadership roles (Hur & Strickland, 2015). If the organization's goal is to diversify the workforce, specifically leadership, then implementing diversity programs and initiatives may not be the best approach (Hur & Strickland, 2015). Instead, organizations may need to gain a better understanding of diversity management interventions to identify approaches better aligned with their organization's diversity needs (Battle et al., 2018; Katz & Miller, 2016).

Chapter 1 includes a discussion of the problem, purpose, and contribution to the knowledge of the current quantitative, correlational study examining the diversity management interventions of health care insurance organizations. The significance of the study is explained by elaborating on how the study contributes to the body of knowledge addressing the impact of diversity management interventions on leadership advancement of minorities. The methodological approach for solving the problem was provided through the nature of the study, research questions, and proposed hypotheses. The context for the study was provided in the theoretical framework and definitions of terms. The assumptions, limitations, and delimitations also provide a framework for the research.

## Background of the Problem

The United States has become increasingly diverse in its demographic composition. According to Cohn and Caumont (2016) from the Pew Research Center, American society is more ethnically and racially diverse than it has ever been. Estimates are that by 2055 there will be no minorities in this country, which is not surprising given that more than half of babies born in the US belong to racial and ethnic minorities (Cohn, 2016). Census Bureau projections, however, suggest that non-Hispanic Whites will lose their majority status even earlier, by 2044. The population of different ethnic groups has

increased steadily. Currently, people of Hispanic origin constitute 17.4% of the total population, while the number of Black and African Americans has reached 13% (Statista, 2017). The Asian community has increased steadily, mainly due to massive immigration (Cohn & Caumont, 2016). Although diversity and immigration may cause hostility and misunderstanding, most Americans claim they are satisfied with the demographic trends and believe that diversity strengthens the country (Cohn, 2016).

However, diversity in American society and within the workforce is reflected not only in ethnic and racial differences. Researchers maintain that it is essential to also consider the diversity issue in terms of age (Keating & Karklis, 2016). The number of young people in the workforce has been increasing. Millennials are expected to become the most numerous and powerful population group (Cohn & Caumont, 2016). Millennials are also the population with the most diverse racial makeup, which puts them under more pressure to manage diversity (Frey, 2018). Furthermore, although women have occupied a prominent place in the workforce since the 1960s, they are still disadvantaged in positions compared to men. People with disabilities and members of the lesbian, gay, bisexual, transsexual or intersex (LGBTI) community also have the minority status in the US, and they may encounter barriers to equal employment and career opportunities (Mpofu & Harley, 2006; Valfort, 2017).

Discrimination against members of minority groups is prevalent in the workplace. In 2014, the Equal Employment Opportunity Commission (EEOC) received more than 31,000 charges of race-based discrimination, but the EEOC dismissed the majority of them. This dismissal highlights how difficult it may be for minorities to protect their rights (Vega, 2015). Belonging to several minority groups at once (e.g., African-

American women, or disabled Hispanics) is even more challenging because such minorities experience double discrimination. For example, 66% of White female scientists reported having to work harder than men to prove their competence, whereas Black and African American women experienced this kind of discrimination much more often (Vega, 2015).

Workplace discrimination starts with the ethnic and racial identification of individuals during the application process or interviews. It is common among employers to identify applicants based on their appearance, culture, accent, native language, or religious and political affiliation, rather than assessing a person's suitability for the job based on skills and experience (Soylu & Buchanan, 2013). Also, further evaluation of an employee in the workplace is subjected to prejudice and stereotyping, which prevents minority people from climbing the career ladder and receiving equal remuneration for their work (Soylu & Buchanan, 2013). Workplace discrimination manifests itself not only in open hostility and verbal abuse but also in unjust practices for assessing and promoting employees. Such promotions are based on employees' race and ethnic status, not their knowledge, skills, and achievements (Freifeld, 2017).

Minorities have always been prevented from receiving promotions and leadership advancements in many organizations. Obstacles or barriers that have prevented advancement have varied from obvious and explicit forms of discrimination, including verbal comments on race, to subtle and less visible forms, such as exclusions from important meetings. In taste-based discrimination, employers may prefer to avoid hiring minorities or will place them into lower paying roles because they are deemed undesirable (Harcourt, Lam, Harcourt, & Flynn, 2008). Statistical (or error)

discrimination, commonly referred to as profiling, occurs when employers choose to screen applicants based on race because it is easier and more cost effective to assess individuals based on race rather than performance and productivity (Harcourt et al., 2008). Finally, according to social capital theory, employer hiring practices are based upon networks; social capital discrimination occurs because minorities are in social networks that are not linked to management or related professions (Harcourt et al., 2008).

Visible forms of discrimination, such as those described above, reached national attention when President John F. Kennedy signed an executive order in 1965, known as Affirmative Action, to address unequal treatment in hiring practices based on race (Kurtulus, 2012). The term "glass ceiling" often refers to artificial or invisible barriers that exist as a result of biases, subtle racism, stereotyping, lack of recruitment, and unwritten organizational rules prevalent within most organizations (Wilson, 2014). According to the glass cliff theory, minorities often only receive promotion and advancement opportunities into top leadership positions when organizations are struggling or performing negatively (Cook & Glass, 2014a). Diversity management is often an organizational response to address workplace inequality and barriers to advancement (Berrey, 2014).

The advancement of minorities in leadership positions, as well as the challenges of shattering the "glass ceiling" has attracted much attention from scholars. Thus, for example, Davis and Maldonado (2015) explored how minority women experience discrimination in the workforce. The researchers argued that African-American women are consistently subjected to bias and stereotyping, especially when they manage to occupy leadership positions in their organizations. This tension occurs because their

majority colleagues cannot accept the changes in historically established gender and race relations (Davis & Maldonado, 2015). Johns (2013) discussed the impenetrable barriers between minorities and leadership positions, noting that women and ethnic minorities experience multiple problems, including societal, governmental, and structural barriers. In most of the cases, it is the very structure of their society and workplace they work in that prevents them from achieving success.

Stereotyping is one of the central issues that prevent racial ethnic minorities from leadership advancement. Festekjian, Tram, Murray, Sy, and Huynh (2013) found that employees' interpersonal and intrapersonal perceptions affected organizational leadership by establishing Caucasian Americans as more suitable for leadership positions compared to Asian Americans, who are currently underrepresented at the executive level. Furthermore, Festekjian et al. (2013) reported that Asian Americans had lower leadership aspirations and intrapersonal leadership perceptions compared to their majority colleagues. In other words, the way others perceived Asian Americans greatly affected how Asian Americans themselves perceived their leadership abilities (Festekjian et al., 2013). Festekjian et al. (2013) added that organizational leaders often make their promotion decisions based on the stereotypes and preconceptions about minorities, which, coupled with minority employees' lack of confidence, results in their underrepresentation in leadership.

**Diversity in the Health Care Insurance Industry**

The topic of diversity expands across many industries. The general problem addressed in this study is the lack of minorities in leadership positions in the health care insurance industry. According to Kay and Gorman (2012), "racial and ethnic minorities

are scarce among managers and executives within organizations in the United States" (p. 91). Only 5% of chief executive officers (CEOs) of Fortune 500 organizations are minorities (Frankel, 2015). While the number of minorities in the United States is increasing, the gap in the number of minorities in CEO roles is not closing at a similar pace (Mycroft, 2012). Minority women are underrepresented in the public and private sectors: Black women occupy only 1.5% of senior leadership, roles whereas White women hold nearly a quarter of leadership positions (Zarya, 2016). Similarly, Asians still hold few positions at management and executive levels, which is surprising given the fact that this group has higher levels of education than Whites and other minorities (Johnson & Sy, 2016). The same tendency exists with other minority groups in the workforce.

Within the health care industry, minorities are significantly underrepresented in executive leadership positions compared to Whites (DiversityInc., 2011; Gathers, 2003; Health Research & Educational Trust, 2016). In a study of 6,338 CEOs working in U.S. hospitals, the Health Research & Educational Trust (2016), an affiliate of the American Hospital Association, identified that minorities held only 14% of hospital board members' roles, 11% of executive leadership positions, and 19% of first- and mid-level management positions. However, minorities comprised nearly 37% of patients in the US. These statistics demonstrate that there is a gap between health care leaders and the constituents or patients that they serve. In 2011, the American Hospital Association (AHA) partnered with the American College of Healthcare Executive, Association of American Medical Colleges, Catholic Health Association of the United States, and America's Essential Hospitals to form the National Call to Action to Eliminate Health Care Disparities (Equity of Care, 2016). The alliance unifies hospitals and health systems

in accelerating actions action to mitigate discrimination, including by increasing diversity in leadership and governance.

Some health care insurance organizations have acknowledged the current demographic and workforce trends and introduced organizational management initiatives to foster diversity. For example, one of the oldest insurance organizations in the US called Aetna announced its commitment to diversity values in the workplace. Its official website claims that women constitute 75% of the total number of employees, and 33% of leaders in the Board of Directors and the Executive Committee (Aetna, 2016). Aetna also has introduced development programs for its minority employees and supported them in career development and planning. Also, the organization offered sponsorship, mentoring, and collaborative programs to employees and provide them with more opportunities to occupy leadership positions. Another insurer, Kaiser Permanente, has been recognized as one of the leading organizations in driving diversity and inclusion. More specifically, it ranked high in talent development, leadership commitment, and mentorship (Kaiser Permanente, 2015). These organizations' efforts at fostering diversity at all levels emphasize its growing importance in organizational management. Still, the majority of insurers are struggling with incorporating diversity management into their operations, which prevents them from catering to their employees and customers' needs (Hollmer, 2016; Milkint, 2016).

Many organizational leaders agree that diversity matters, but leaders differ on the methods to address problems in achieving diversity in management (Dotson & Nuru-Jeter, 2012). In a health care study of 3,007 non-federal, short-term general hospitals, 48% of the hospitals had a leadership development program yet only 37% had a diversity

plan to ensure the composition of the leadership and workforce reflects similar racial demographics to the constituents they serve (Kim, Thompson, & Herbek, 2012). In line with the different adoption rates in initiatives, there are different approaches to diversity in management.

Varying approaches to achieving diversity in management may exist, in part, because there are conflicting arguments regarding whether or not diversity influences financial profitability, which is an important factor that organizational practitioners use in decision-making and strategic planning (Singal & Gerde, 2015). Dotson, Nuru-Jeter, and Brooks-Williams (2012) contended that there might be a direct relationship between health disparities and management that lacks cultural sensitivity. Improving diversity in leadership may have many benefits, including positively impacting patient outcomes. While diversity itself may not have a direct impact on the material capital of an organization, diversity influences intellectual capital which can directly impact material capital and business performance (Wondrak & Segert, 2015). Olson, Parayitam, and Twigg (2006) further suggested that when leaders endorse diversity as a strategic initiative, they can influence the cohesion among team members in strategic decision-making, which improves organizational performance. Benefits of diversity may include increased innovation and productivity, reductions in stereotyping, cultural awareness and sensitivity, legal compliance, and less litigation (Wilson, 2014).

Diversity in health care leadership has multiple advantages, and health care generally workers view diversity positively (Silver, 2017). Leaders use diversity to facilitate decision-making by uniting the experiences and beliefs of people from different cultures and backgrounds. Moreover, diversity in health care improves the quality of

services delivered to clients by creating a culturally competent and tolerant atmosphere. Employees acknowledging and valuing diversity in their team are better prepared to address the needs of diverse customers, which leads to improved client satisfaction. Leaders use diversity to affirm commitments by empowering employees and motivating them to work harder. Moreover, a recent study by Silver (2017) explored health care executives' attitudes to diversity leadership and found that respondents valued diversity in the workplace and believed that organizations should give more leadership opportunities to people of color.

Organizational leaders should be made aware of the demographic make-up of their workforce and customers and be trained in the relevance of such diversity or lack thereof (Grant, 2010). Specific training for existing and aspiring leaders is necessary as "diversity tests leadership skills at a deeper and more personal level than homogeneity does" (Dreachslin, 2007, p. 151). The GilDeane Group (2005) suggested that for both leadership development programs and diversity initiatives to be successful, they should both be tied to a) metrics validating an organization's leadership and b) diversity strategies that give the organization a competitive advantage. Organizations support diversity management through directing funding towards diversity plans and establishing follow-through from senior leadership to achieve positive outcomes (Garr, 2014).

Frankel (2015), in a DiversityInc article, suggested that three primary dimensions to interventions that influence diversity in management are mentoring, employee resource groups, and talent development. Workplace mentoring is the relationship between two or more employees in which more experienced and competent employees teach those lacking the required knowledge and expertise. Although initially,

mentoring implied the face-to-face, hierarchical relations between a senior and junior employee, recently, this term has acquired a broader meaning. Contemporary workplace mentoring may take place in networks and teams, allowing for greater interaction and flexibility (Allen & Eby, 2011). As an institutional-level initiative, formalized mentoring programs are believed to bring benefits to the training, recruitment, and retention of diverse employees (de Dios et al., 2013). De Dios et al. (2013) stressed that formal mentoring programs are more successful in promoting diversity compared to informal interventions because underrepresented minorities rarely have access to informal workplace networks. Notably, all DiversityInc Top 50 organizations have formal mentoring programs while only 18% of organizations in the US have such programs, which indicates that this practice is rarely used in the American workplace setting (Frankel, 2015).

Affinity group, also known as an employee resource group, business resource group, or associate resource group, is another organizational practice employed to facilitate diversity in the workplace. Affinity groups are defined as "a group of employees who come together for a common business mission and reflect a common characteristic" (Feldman et al., 2011, p. 136). Affinity groups usually are organized by employee volunteers and can be used to successfully foster a favorable working environment in which all team members feel respected and cared for (Ribiere & Worasinchai, 2013). Affinity groups are effective when employees experience subtle problems that organizations cannot address with more formal measures (e.g., a lawsuit). According to Frankel (2015), the adoption of employee resource groups among DiversityInc Top 50 organizations has increased from 15.8% in 2008 to 25.3% in 2014 to 44.1% in 2015.

Finally, diversity training and development are also used to foster the culture of equality and diversity in the workplace. Training and development are defined as "the process of systematically teaching employees to acquire and improve job-related skills and knowledge" (Chaunda, 2012, p. 246). As the issue of diversity has occupied a central place in organizational management over the past several decades, training and development have incorporated such considerations as learning preferences, educational background, and cultural perspectives. In this way, employee resource groups and mentoring help remove minorities from isolation while training and development help organizations put structures in place to manage diversity and facilitate diversity in management (Kalev et al., 2006). Understanding the influence of diversity management interventions may offer a solution for organizational practitioners seeking ways to prioritize interventions aimed at improving diversity in leadership and maintaining diversity for long-term sustainability.

## Statement of the Problem

With the changing demographics of the U.S. society, it is vital for both private and public sectors to keep up with these changes. According to the prognoses, minority populations may soon outnumber the current majority, which means that minorities will play a significant role in the workforce (Harnik, 2016). Unfortunately, the general problem is that there is an alarmingly low representation of minorities in the workforce, and the health care industry specifically, even though minority populations in the US are increasing rapidly. A survey conducted by the Health Research & Educational Trust's (2016) Institute for Diversity in Health Management found that minorities represented 32% of all patients nationally, but this population group constituted only 14% of hospital

board members. Although there is no up-to-date information regarding minorities in health care insurance organizations, the general trends in the workforce would suggest that this industry is also dominated by the majority. This astonishing lack of diversity among health care's leadership and top management is evidence that the industry fails to empower and support diverse employees and help them climb the career ladder.

This lack of diversity in health care insurance organizations has a detrimental effect on the whole system. Many people believe that diversity and cultural acceptance play an essential role in the quality of services health care providers deliver to their clients, as well as the way they interact and communicate with them. The workforce that does not resemble the demographic make-up of its customer base risks being affected by stereotypes and discrimination. Moreover, given the increasing number of minority Americans, it is expected that more people from diverse backgrounds will seek insurance organizations' services (DiversityInc, 2012a). However, the lack of long-term commitment to culturally competent care and diversity management may prevent health care insurance organizations from improving their market share and delivering relevant services. Employees who are unaware of the challenges and problems minority status can bring may not be able to help their clients and provide culturally specific care (DiversityInc, 2012a).

The specific problem is that it is unknown how minorities' perceive the relationship between diversity management interventions and leadership advancement of minorities in health care insurance organizations. The three diversity management interventions of interest for this study, measured by the Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey (Appendix A), are

affinity groups, mentoring, and training and development. A secondary focus of this study was the lack of diversity planning and leadership development activities within health care insurance organizations which is suggestive of a lack of diversity in management, poor organizational performance (including employee dissatisfaction), increasing employee turnover, and poor organization profitability (Health Research & Educational Trust, 2016; Kim et al., 2012; Richard, 2000). Minority status is a factor that prevents talented and skilled employees from contributing their knowledge and commitment, and this deficit ultimately affects all stakeholders (Salomon & Schork, 2003). Poor diversity management and a lack of affinity groups, mentoring, and leadership training mean that these people may not get the needed support, training, and mentorship that could help them become competent and valuable team members (Salomon & Schork, 2003). Additionally, a lack of understanding of diversity creates a hostile workplace atmosphere characterized by intolerance, inequality, and discrimination (Joshi Pant & Vijaya, 2015). One cannot deny the fact that under these conditions, organizations in the health care market, including insurers, may not be able to deliver excellent services and compete (Bertone & Leahy, 2001).

Furthermore, traditional leadership theories have attributed the advancement of leaders to the possession of certain traits and behaviors, emotional intelligence, or situations. The failure to incorporate diversity into leadership theory, moving beyond traditional paradigms to social contexts, leads to an inadequate understanding of how to prepare minorities for leadership and how to advance minorities into leadership roles when they are adequately prepared (Chin, 2010; Eagly & Chin, 2010). Understanding whether specific diversity management interventions may be influential in the leadership

advancement of minorities may assist health care insurance organizations in developing best practices and prioritization of interventions.

Through the use of a quantitative, correlational design, this study's objective was to understand the relationship between minorities' perceptions about diversity management interventions (the independent variable) in health care insurance organizations and the leadership advancement of minorities (dependent variable). An abundance of literature with a focus on diversity management interventions exists to assist in addressing the problems of diversity in organizational management. However, focused studies regarding specific types of diversity management interventions in health care insurance organizations, such as Aetna, Anthem, Centene, Cigna, Humana, Kaiser, and UnitedHealth were not found. Nor was there literature that documented minorities' perceptions of diversity management interventions and the use of such inventions to assist with leadership advancement in health care insurance organizations. This study aimed to fill in the gaps in which the literature is lacking.

## Purpose of the Study

The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the United States. This study was expected to contribute additional knowledge learned through the use of multiple regression analysis on information collected from employees working in health care insurance organizations. Findings may help organizations to understand better ways in which minorities perceive diversity

management interventions and their effectiveness related to advancement; however, the study did identify actual underlying issues.

## Significance of the Study

This study's focus was on minorities' perceptions of the effect that diversity management interventions may have on the advancement of minorities in leadership positions. Affinity groups, mentoring, and training and development programs are thought of as educational and skill-building activities aimed at improving the leadership capabilities of individuals. By understanding the relationship, organizational practitioners in health care insurance organizations may be able to develop initiatives more effectively that consequently may impact diversity in management. Continued discussions on the topic of diversity also may assist with helping to raise awareness of diversity issues in management and result in additional solutions to address the issue. The researcher also expected that this study would generate valuable knowledge regarding minorities' promotion to leadership positions, which may have a positive effect on health care insurance organizations and their operations.

It is important to recognize that diversity training and mentorship programs are only one approach to achieving diversity. However, these practices have a positive short-term social-psychological effect but no impact on a long-term, sustainable diversity atmosphere (Ehrke, Berthold, & Steffens, 2014). Making diversity a part of the organizational structure and its mission requires promoting minorities to top leadership positions and respecting their right for equal and just treatment. It is critically important to incorporate minorities into leadership because there is evidence that minority leaders have a dramatic impact on organizational change. Chin (2013) argued that minority

leaders tend to use their experiences of marginalization and discrimination as a powerful resource and strength rather than as a weakness that holds them back. Their unique perspectives can inform the exercise of leadership and promote effective decision making, which is the driver of success in any organization.

## Overview of Research Methodology

This study consisted of a quantitative, non-experimental, correlational research design. Quantitative research methodology includes numerical results and statistical inferences to understand different behaviors and to show the applicability of a smaller population in sample surveys to a larger population (Iversen, 2004). Because a control group was not used in the study, the quantitative method was non-experimental. Quantitative methods were used to classify responses received from the Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey into diversity management themes of affinity groups, mentoring, and training and development. Diversity for this study's focus was on race as self-reported in the demographic section of the survey.

The correlational research design is employed to measure the strength and direction of the relationship or association between two or more variables in one group of subjects. It is useful when the researcher selects variables that can be measured statistically and is interested in determining how they relate to each other. When an increase in one variable leads to an increase in other(s), one can conclude that a positive correlation exists between them, whereas negative correlation is found when an increase in one variable leads to a decrease in another. The correlational research design is weaker compared to the experimental one because it does not allow for the actual manipulation

of variables, which means that it does not determine the cause-and-effect relationship (Lavrakas, 2008). A quantitative, correlative research method and multiple regression analysis were appropriate for this study as researchers use correlational studies to predict or to determine a relationship between variables (Black, 2002). More specifically, this study consisted of a correlational research design to determine if there was a relationship between the independent variable, defined as diversity management interventions, and the dependent variable, defined as the leadership advancement of minorities.

Furthermore, the data for this study were analyzed using regression analysis, which is a statistical methodology that researchers use to determine the correlation between dependent and independent variables (Sen & Srivastava, 2012). Regression analysis cannot be used to explain or predict the relationship between variables but is suited only for determining whether this relationship exists. Regression analysis can be either single (one independent variable) or multiple (two or more independent variables). The independent variable, diversity management interventions, consisted of affinity groups, mentoring, and training and development while the dependent variable was the leadership advancement of minorities in health care insurance organizations in the US.

## Research Questions

The following research questions were used to guide this study regarding diversity management interventions within health care insurance organizations:

1. Is there a relationship between the perception of minorities about diversity management interventions and leadership advancement of minorities in health care insurance organizations?

2. Which of the three types of diversity management interventions (affinity groups, mentoring, and training and development) have a greater relationship with the leadership advancement of minorities in health care organizations?
3. To what degree do minorities perceive promotional opportunities are available to them in health care insurance organizations?
4. To what degree do minorities perceive they have an understanding of how to advance in leadership in health care insurance organizations?

The independent variable was diversity management interventions, identified as affinity groups, mentoring, and training and development. The dependent variable was the perceived advancement of minorities into leadership positions of health care insurance organizations.

## Hypotheses

Three main hypotheses were the basis for this study:

$H1_0$: There is no significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations.

$H1_A$: There is a significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations.

$H2_0$: There is no significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations.

$H2_A$: There is a significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations.

$H3_0$: There is no significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations.

$H3_A$: There is a significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations.

## Theoretical Framework

Olsen and Martins (2012) introduced the concept of instrumental and terminal values, which serves as one of three paradigms that guide the theoretical framework for this study. Olsen's and Martins's (2012) theoretical framework on conceptualizing diversity management approaches demonstrated that organizations do not value diversity the same. Instrumental values are beliefs that specific actions and behaviors will lead to the desired end-state. Organizations view diversity as an instrumental value when they see diversity for potential positive implications to individual and business performance. Conversely, terminal values are focused specifically on end-state. Organizations that focus on diversity solely to achieve diversity specific objectives, such as to meet equal employment opportunity requirements or to avoid potential discrimination lawsuits, hold diversity as a terminal value.

The degree to which an organization values diversity will have implications for diversity in the workforce and diversity in management. The more an organization values

diversity, the more likely there is to be a more abundant source of applicants for hiring and ultimately promotion into leadership (Rabl & Triana, 2014). Under this association, organizations investing more in diversity management interventions which go beyond meeting equal employment opportunity requirements may have more of an influence on the advancement of minorities into leadership positions.

Based on the resource dependency theory (RDT), external resources are critical to an organization's success (Pfeffer & Salancik, 1978). The assumption is that the most effective way to the company's survival and long-term success is its ability to accumulate resources. These resources may include personnel, technology, information, raw material, and so on. Unlike resource-based view of the firm (RBV) focusing on internal resources and in line with RDT, organizations cannot produce all required resources internally (Nöhren, 2015). In other words, to survive, organizations need to seek resources in their external environment. Moreover, as maintained by RDT, adaptation to the external environment is not passive but instead requires a strategic choice and ongoing commitment.

Affinity groups, mentoring programs, and training and development programs are examples of external resources because the programs are not representative of the core operating functions of the organization. According to RDT, organizations need to incorporate active management practices to facilitate operation and commit to changes at all executive levels. However, health care insurance organizations must proactively manage these resources in environments of uncertainty, such as the unknown impact of PPACA. Kim et al. (2012) have shown leadership development programs may be used as

a leveraged tool because of the positive relationship the programs have on organizational factors such as hospital size and accreditation.

According to Mgbere (2009), there is also a positive relationship between organizational culture and corporate performance. RDT followers would, therefore, support the phenomena being seen with hospitals within the health care industry increasingly developing leadership development programs and diversity initiatives to help build leadership competencies in a health care environment when there is downward pressure on revenues and increasing competition (Kim et al., 2012). Similar findings may hold in health care insurance organizations when examining diversity management interventions and the relationship to leadership advancement.

Last, GilDeane Group's (2005) integrated global strategic and program approaches, which studies nine Fortune 500 organizations (e.g., Coca-Cola, Ford Motor, Wells Fargo), identified organizations with diversity councils develop accountable and formal diversity strategies and track organization performance through assessment metrics. According to this theory, organizations achieve higher levels of employee satisfaction, greater diversity, improved productivity, and revenue growth through leadership commitment (GilDeane Group, 2005). Investments in diversity management interventions may result in many benefits including increased diversity in management and the removal of minorities from isolation. Moreover, enhanced diversity management can positively affect the quality of delivered services by making employees more sensitive to their clients' needs.

## Definitions of Terms

The following terms are used to provide clarity on commonly-used words and phrases when discussing diversity, health care, and leadership. These terms, however, can take on different meanings and are defined to reduce ambiguity that may otherwise exist in the study:

*Affinity groups.* Affinity groups also are referred commonly to as advocacy groups, focus groups, networking groups, employee resource groups, or support groups. Organizations often provide an opportunity for employees to network and interact with others in the organization of similar demographic characteristics, such as race, gender, and sexual orientation, through collective groups known as affinity groups ("Employee affinity groups," 2006). Generally, the belief is that affinity groups contribute to the sense of connectivity and community, thus reducing the mistrust and social tension that often exist within diverse employee groups (Feldman et al., 2011). Although at first glance, affinity groups may look like social enclaves that further isolate a particular group of employees, they provide substantial support for underrepresented team members (Schneider & Barbera, 2014).

*Diversity*. Diversity is used to refer to the different demographic characteristics that individuals often identify themselves or find commonalities, such as age, disability, gender, race, religion, national orientation, and sexual orientation (Wilson, 2014). Research on diversity increasingly began to focus on diversity within organizations and work teams in the 1990s (Shore et al., 2009). The term workforce diversity widely used by researchers refers to the workforce made up of representatives of different

demographic groups, who enjoy equal job opportunities, treatment, and rights irrespectively of their background (Scott, 2012).

*Diversity management interventions.* Diversity management interventions are organizations actions, such as diversity training, education, mentoring, leadership development, and team building, aimed at increasing diversity and awareness of diversity issues (Curtis & Dreachslin, 2008).

*Health care organizations.* Health care organization is a widely used term to categorize individuals directly involved in patient and consumer health care or organizations that may provide health services (primary providers), provide resources to help support the health care system (secondary providers), regulate and provide oversight to primary and secondary providers, or represent primary and secondary providers (Swayne, Duncan, & Ginter, 2013).

*Health care insurance organizations.* Health care insurance organizations are considered primary providers of health services as they offer medical coverage to individuals in the form of health care insurance and may provide ancillary services, such as nursing advice lines and authorize of benefits (Swayne et al., 2013). The most prominent health care insurance organizations in the United States include UnitedHealth Group, Anthem, Kaiser Foundation Group, Aetna, Cigna, Humana, Centene, and others (Heilbrunn, 2014).

*Mentoring.* Mentoring, as a type of diversity management intervention, is a tool where a more senior person, who is usually in a position of a higher rank, advises a less seasoned employee on career and personal development (Curtis & Dreachslin, 2008). Mentors typically have more significant influence, experience, and achievement

compared to their protégés, so they can offer the needed protection and support to employees feeling less confident in the organizational environment. Diversity mentoring in the workplace relates to not only the provision of support to racial minorities but also the empowerment of people with other sources of disadvantage (Clutterbuck, Poulsen, & Kochan, 2012).

*Minorities.* In 2010, the United States Census had races separated into six categories according to 1997 Office of Budget and Management directives: White, Blacks or African Americans, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and Some Other Race (United States Census Bureau, 2013). Minority groups are those that are not the majority, which is comprised of Whites according to U.S. Census data. Blacks, Asians, and Hispanics are the target minority population for this study. From the broader perspective, the term minority refers to populations differing from the majority in some characteristics, such as gender, religious affiliations, culture, sexual orientation, and so on (Zirk-Sadowski & Wojciechowski, 2016).

*Training and development programs.* Leadership training and development programs are a type of diversity management interventions and include 360-feedback assessment and executive coaching (Thach, 2002; Thompson & Temple, 2015). These programs commonly are viewed as a method for leaders and managers to retain, develop, and promote employees within the organization without the additional financial burden and resource commitments necessary to educate and train new employees about the organization's business model. Diversity training and development programs are directed

at eliminating discrimination and harassment, providing knowledge and skills, and optimizing employees' talent (Gündemir, Dovidio, Homan, & De Dreu, 2017).

## Assumptions

There are several underlying assumptions for this study. First, that participants surveyed provided unbiased, perceived views of their organizations. There is no mechanism to verify that participants provided truthful responses and unbiased perceptions of their organization's diversity management intervention programs. Because individual and organizational identities were kept anonymous, there was no incentive for participants to disclose information that is truthful and unbiased. Also, the presumption was that this study could help decision makers within health care insurance organizations to adopt diversity management interventions towards increasing minority representation in leadership.

This study also was based on two theoretical assumptions. While minorities can achieve career advancement on their own, minorities have better success in achieving leadership advancement when there are organizational diversity interventions and initiatives aimed at mitigating racial barriers or assisting minorities with overcoming such barriers. Second, the care of patients is better served when the leadership and workforce of health care insurance organizations consist of similar demographics.

## Scope of the Study

This study's focus was on diversity and organizational management in health care insurance organizations and does not include other health providers. The participants for this study consisted of a convenience sample of leaders (i.e., managers, directors, senior directors, associate vice presidents and above) from health care insurance organizations

within the United States. Data were collected through an online survey, and the results were analyzed using correlational analysis, multiple regressions, and reliability analysis. The main aspects that were evaluated included the perceptions of diversity management interventions and their relationship to the perceptions of leadership advancement of minority employees.

## Limitations

A limitation presented in this study was the focus on the perceptions of minorities. This limitation represents a cultural bias but also presents the experiences of those intended to be most impacted by diversity management interventions. Participants' self-reported demographic data and survey responses. While there is the possibility that participants may have falsified their racial identification and other demographic information, an incentive to do so was not provided in support of the goals of the study. The study was further limited by the sample population and the research design. Small population size may not be fully indicative of a larger phenomenon. Correlational research design was employed following the collection of participants' survey question responses to determine if there is a relationship between the independent variable, defined as diversity management interventions, and the dependent variable, defined as the leadership advancement of minorities. The research did not exist that proved the success of diversity management interventions.

## Delimitations

This study was limited to participants within the health care insurance industry. It was limited to the survey questions focused on diversity-themed leadership development programs. This study was also limited to the self-reporting data of participants' responses

to the survey questions. The study was limited to the influence of the three types of diversity management interventions. Although the perspective of minority non-leaders would contribute much to the understanding of diversity management in the insurance industry, non-management employees were not included in the sample. Additionally, participants were not asked questions that specifically revealed overall key business strategies of their organizations.

## Summary

As American society becomes more diverse, private and public organizations should address increases in diversity in the workplace, allowing diversity to become an asset as opposed to an impediment. Companies that manage to create a favorable workplace atmosphere for minorities will get a competitive advantage in years to come because this population group is expected to grow more numerous (Cohn & Caumont, 2016). There is a strong need for organizations in the health care industry to eliminate discrimination and bias and create opportunities for their employees irrespectively of their ethnic, racial, or cultural background. Diversity management programs in the workplace are necessary to deal with demographic changes in society and deliver better and more relevant services. Moreover, leadership development is probably the most crucial aspect that can help combat discrimination and create a culture of tolerance and equality.

The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health care insurance organization in the United States. The Organizational Diversity Management

Interventions Climate Assessment (ODMICA) survey (Appendix A) was used to collect the data for this study (Wallner, 2008). Data were collected from minority managers in the health care insurance industry.

## Organization of Dissertation Chapters

Chapter 1 consisted of an overview and framework for the current study, including discussion of the problem and purpose statements, research questions, theoretical framework, definitions, assumptions, limitations, and delimitations. Chapter 2 is a literature review that provides a historical context for workforce diversity management interventions and leadership advancement. The literature review includes an understanding of the gaps in the literature on the interaction between diversity management interventions and leadership advancement to influence diversity in management positions. Chapter 3 consists of an overview of the research design and methodology used to answer the research questions guiding this study. The results and findings from the study's data analysis and testing of the hypotheses are provided in Chapter 4. Summary conclusions, interpretation of the results, implications, and suggestions for future research on the topic of leadership advancement of minorities in the health care insurance industry are contained in Chapter 5.

# Chapter 2

## Review of the Literature

The purpose of this quantitative correlational study was to examine potential relationships between the perceptions of minorities regarding three diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the United States. In this study, the researcher explored whether or not an emphasis on diversity management interventions could enable organizations to develop long-term strategies for facilitating the leadership advancement of minorities. This chapter includes a review of related literature to facilitate an understanding of the importance of diversity in the workplace, diversity management, and leadership advancement programs. The role of leadership and effective approaches to leadership in the organizational setting are also discussed. Further, this literature review includes a discussion on how diversity training and leadership development programs contribute to diversity in management and corporate profitability.

There is limited literature on the leadership advancement of minorities in health care organizations. During the literature search, the researcher utilized ProQuest, EBSCO, and Google Scholar databases to identify studies on the advancement of minorities in health care leadership positions. The researcher also relied on nonpeer-reviewed health care journals and industry publications on diversity, such as Diversity, Inc., the National Association of Health Services Executives (NAHSE), the American College of Healthcare Executives (ACHE), and the Health Research & Educational Trust. Multiple iterations and combinations of the terms and phrases were used in the search, for example, *organizational leadership, minorities in health care leadership, diversity in*

*health care organizations, diversity management, and leadership advancement of minorities in health care*. Because of the lack of information on health care insurance organizations, most of the literature cited in this chapter is focused on clinical positions, such as those of nurses and doctors, which are directly related to patient care instead of the corporate side of health care and health care organizations.

## Leadership in the Organizational Context

The concept of organizational leadership is complex. A large body of research on leadership was available, which presented a multitude of definitions of this term. The traditional perspectives defined leadership as a process of guiding people with the primary aim of creating coordination, compliance, and respect (Eustace & Martins, 2014). Leadership is key to success in the organizational environment, irrespective of the type of organization and focus area. Leaders establish the vision and set the direction for organizations. They lead and develop employees by demonstrating competencies and creating and communicating a shared vision, thereby enabling subordinates to act on and execute that vision (Ahmet, 2015). Effective leaders lead through the use of emotional intelligence, continual learning, and exhibiting their leadership capacity or helping others around them (Yost, 2014). According to Babinski (2016), successful leaders can apply their knowledge and skills to influence strategic thinking and raise organizational expectations and employee performance.

Leadership has an affect on fundamental organizational aspects, including organizational health, culture, employee attitudes, productivity, and morale. Leaders are responsible for creating a favorable corporate culture, which is defined as the pattern of underlying assumptions and behaviors that a group accepts as the correct way to perceive,

think about, and address emerging problems (Belias & Koustelios, 2014). By instilling shared values and goals in their staff, leaders can initiate and sustain changes in the workplace, which ultimately improve employee relationships, productivity, and overall organizational success. Further, leaders are believed to contribute to creativity, shared vision, increased trust within the team, and the focus on continual development (Naile & Selesho, 2014). Effective approaches to leadership can also result in increases to job satisfaction and organizational commitment (Mosadeghrad & Ferdosi, 2013).

The success of leadership as a process of guiding employees and driving change is closely related to the broader concept of leadership management. According to Wu (2013), leadership management is a factor in all day-to-day organizational activities. This term is used to refer to activities performed by someone who is in a position to lead others, even those who are not in managerial positions. Leadership management can be considered the intersection of two primary organizational activities—leadership and management. As noted by Wu (2013), in any organizational setting, leadership activities are closely related to managerial ones, and one person can successfully inculcate in others the required practices and values, thereby ensuring the stability and effectiveness of corporate activities. Therefore, leadership management may be summarized as the process of motivating and driving employees to succeed, while simultaneously organizing work at each level.

**Classical and Germinal Theories**

Both leadership and management have a strong theoretical basis. An overview of traditional theories in the workplace can help explain how the intellectual and technological aspects of leadership management have developed, as well as provide an

outline of the methods of and approaches to leadership and management that can promote success and efficiency in a demanding workplace setting.

**Scientific Management.** The role of employees in organizational success did not receive attention until the mid-1900s. In the early 1900s, Frederick Winslow Taylor's scientific management theory emphasized the interactions between people and technology in managing large industrial systems (Grachev & Rakitsky, 2013). Taylor's management paradigm focused solely on the intellectual and the productive efforts of employees and managers, paying attention to time management and the division of labor (Grachev & Rakitsky, 2013).

**Human Factors**. Frank and Lillian Gilbreth built upon Taylor's scientific management principles, adding the psychological aspects of the workplace. According to Graham (2013), "Gilbreth showed that the individual's point of view was essential to understand, and this was a necessary first step before considering how the group could impact the points of view of its individual members in the workplace" (p. 355). Gilbreth identified that individual factors, like personal plans after work, positively influenced productivity. This discovery led Gilbreth to recommend that organizations must encourage each employee's ability to express themselves in the workplace (Graham, 2013).

**Concern for People.** In the 1920s, humanism became a key focus for organizations that sought to improve their performance. Elton Mayo and Fritz Roethlisberger demonstrated that the concern for the socio-psychological aspects of human behavior was more important than working conditions or financial incentives (Roethlisberger & Dickson, 1949). Even in highly computerized industries, where

machines perform much of the work, the human factor plays a critical role. Socio-psychological aspects, such as a sense of belonging and recognition, can significantly affect organizational success; thus, particular attention must be paid to cherishing these aspects in employees (Kilpatrick, 2009).

Mayo and Fritz Roethlisberger revolutionized the manner in which organizational practitioners perceived employees through their Hawthorne study (Roethlisberger & Dickson, 1949). Instead of treating workers as soulless machines that submissively perform their duties, organizations must recognize them as real people with all their concerns, attitudes, beliefs, and problems (Pershing & Austin, 2014). This idea led to multiple studies on the role of motivation, job satisfaction, organizational culture, resistance to change, and effective leadership in achieving success. The Hawthorne study was as a foundation for modern theories on human relations and contributed to the development of various leadership and management theories concerned with employee motivation and interaction within the organizational environment.

**Humanistic Leadership.** The development of management and leadership theories and their growing focus on human relationships have led to the informed development of humanistic leadership; these theories have been widely accepted in the health care sector. According to Kilpatrick (2009), historically, discussions on humanism were focused on clinicians and their behavioral influence on patient care. However, organizational members other than clinicians are also crucial to the effective delivery of health care. Humanistic leadership emphasizes that leaders must serve both their employees and patients. The humanistic style also assumes that a leader must demonstrate an appreciation of every employee's human potential, encourage

constructive interaction among team members, and enhance the use of available human resources (Northouse, 2012).

Other popular models that focus on the relationship between leaders and followers include Kenneth Blanchard and Paul Hersey's situational leadership theory, James Burn's theory of transformational leadership, and Robert Greenleaf's servant leadership. According to the situational leadership model, leaders can direct, coach, support, or delegate—depending on the needs of their followers—in order to achieve organizational objectives (Marques, 2015). The main idea of this model is that there is no ideal way to lead people; instead, the approach to leadership must change under varying conditions to meet employees' needs (Dugan, 2017). The inference is that employees who lack skills in tasks and activities require more supervision and support compared with those who possess the necessary competences. In this manner, situational leadership is used to enable the direction of resources to the most important areas or to those areas that need improvement, while leaving sufficient space for the growth and success of high-performing team members. In addition, in contrast to the idea that "leaders are born," situational leadership maintains that leaders are created—they are the products of situations and the environment that shapes their attitudes and behavior (Dugan, 2017).

Under the transformational leadership theory, leaders must gain the loyalty, trust, and respect of their followers—all of which are necessary for organizational change—by inspiring and creating an emotional bond with them (Clawson, 2006; Nahavandi, 2006). Transformational leaders create shared values and align people to grow and advance professionally and personally. They inspire their followers and nurture their confidence in achieving ambitious goals (Rigolosi, 2012). Further, unlike transactional leadership that

is focused on task orientation and completion, transformational leadership is more concerned about individual consideration and empowerment. Transformational leadership is one of the most suitable approaches that can be used to change organizational culture (Veiseh, Mohammadi, Pirzadian, & Sharafi, 2014). Transformational leaders can positively influence employees' morale and motivation (Rawat, 2015), and can also improve job performance in a variety of organizational settings, such as education, business, and health care (Jyoti & Bhau, 2015).

The servant leadership theory is another approach to leading employees (Trastek, Hamilton, & Niles, 2014). The author of this theory, Robert Greenleaf, argued that people become servant leaders when they wish to serve others in the first place (Trastek, Hamilton, & Niles, 2014). They do not focus on themselves, seek authority, or use their position to exercise power. Instead, servant leaders focus on serving the needs of their followers. In addition, servant leaders promote employee development and always put team members first, which enables the creation of an atmosphere of trust and respect (Trastek, Hamilton, & Niles, 2014).

**Leadership in Health Care**

Leadership has a critical role in the contemporary health care industry. In a demanding and fast-changing health care sector, leaders occupy a prominent position, as they manage limited resources and help to meet increasing consumer demand. They must navigate through the complex needs of regulatory requirements, financial constraints, and consumers. They also are responsible for the provision of high-quality services and maintaining client satisfaction and safety.

Moreover, leaders help create a shared vision and strategic direction for their followers, which is critical for driving ongoing and systematic practice development (Martin, McCormack, Fitzsimons, & Spirig, 2014). Leaders find a balance between organizational requirements and demands on the one hand and the concerns and interests of followers on the other, thereby achieving high organizational performance and stability of the system. However, despite the growing awareness of the importance of leadership, few studies have a focus on this aspect from the organizational perspective, with the main attention being paid to clinical and nursing leadership (Baker, 2011). There is a strong need to understand how leadership shapes organizational strategy and contributes to higher effectiveness in non-clinical settings—such as, for example, the insurance industry.

Ellis and Abbott (2013) emphasized the necessity of distinguishing between health care leaders and managers. They noted that leaders set the tone and direction for their employees, whereas managers set the plan and expect their subordinates to complete tasks (Ellis & Abbott, 2013). Further, leaders are concerned more with the overall workplace atmosphere and long-term success rather than the achievement of short-term goals. Moreover, leaders inspire innovation, while managers inspire stability (Ellis & Abbott, 2013). Certain clinical and organizational settings require leaders to take on both roles, which implies that leaders must possess a substantial scope of skills and knowledge to adequately perform their duties.

Effective health care leadership that is inclusive of all stakeholders' needs has a positive influence on the quality of services, organizational performance, and workplace culture. Leaders who are able to adapt to the emerging needs by using transformational or

transactional leadership can increase productivity and commitment among employees and improve their performance (Khan, Bukhari, & Channar, 2016). Similarly, Mosadeghrad and Ferdosi (2013) found that leadership in the health care sector is directly related to commitment and job satisfaction. As reported in a study by West, Lyubovnikova, Eckert, and Denis (2014), leaders nurture high-quality care cultures and instill positive values by practicing collective leadership. Furthermore, Taplin, Foster, and Shortell (2013) argued that organizational leaders must train and support teamwork because it directly affects employees' abilities to interact and communicate effectively in the process of working towards shared goals.

Further, it has also been found that effective leadership facilitates the provision of culturally competent services, which is critical in the face of growing globalization and migration. Thus, Dauvrin and Lorant (2015) argued that leaders in both clinical and organizational settings are the so-called "champions" in terms of instilling the values of tolerance and competence in the workplace. Leaders are champions because they help create norms and practices that are further accepted and spread among team members to deliver patient-centered services. More than anyone else, it is organizational leaders who can change the existing culture and drive the values of diversity and multiculturalism (Dauvrin & Lorant, 2015).

Despite the widespread recognition of the importance of leadership in the health care sector, there are considerable barriers to participation (Daly, Jackson, Mannix, Davidson, & Hutchinson, 2014). Stanley (2012) argued that even when organizations are aware of the potential of their employees and are prepared to support and nurture them in leadership roles, these employees rarely see their own potential and do not believe in

themselves. Further, hierarchical structures and the lack of strategic vision regarding organizational leadership prevents talented and committed employees from climbing the career ladder or at least attempting to lead in their small teams. An inadequate level of accessible leadership education and training is another challenge, which is further aggravated by the lack of opportunities and motivation (Florida Center for Nursing, 2014).

## Workforce Diversity

Before discussing the notion of workforce diversity in detail, it is essential to define the term "diversity" and understand how it relates to the current demographic and social trends. Diversity is an extremely complicated notion, which can be viewed from different angles. From the conceptual perspective, diversity is used to refer to population groups that are characterized by a few differences compared to the majority (Williams, 2013). From the perspective of group identity, diversity refers to "multiple identities" that define peoples' "experiences, worldview, and the ways in which others respond to them" (Williams, 2013, p. 85). In addition, diversity can be understood from additional perspectives as well, such as economic, equity, centric, and universal aspects.

Further, Williams (2013) explained that diversity is closely related to the concepts of equity, inclusion, and multiculturalism. Multiculturalism is defined as the coexistence of different gender, religious, ethnic, and sexual orientation groups within one community or society. This term is opposed to monoculturalism, which refers to the limited assimilation and supremacy of one group. Equity refers to the social norms and practices that allow treating each member of the society in an equal and just manner, irrespective of his/her background (Williams, 2013). Finally, inclusion is the idea or

philosophy that each person, particularly belonging to the disadvantaged or minority groups, should be provided with equal opportunities. As is evident, these four concepts are interrelated and emphasize the need to protect diverse identities, while simultaneously including them in society on similar terms.

The issue of diversity came into prominence in the 1960s and 1970s, when the American society was torn by racial discrimination (Norton, Sheriff, Blight, Chudacoff, & Logevall, 2011). In the following years, numerous immigrants from all parts of the world came to the US, making the country even more diverse in terms of ethnic and cultural identities (Norton et al., 2011). However, a majority of the population abused minorities' rights and limited minorities' access to similar opportunities. There was a growing understanding that without diversity and inclusion, the multicultural American society would not be able to achieve stability and peace. Thus, the urgent need to provide equal protection to all citizens and create a tolerant and united society become apparent through the changing demographics.

The terms diversity and inclusion are associated with equal opportunities for all citizens, as well as actions directed at managing differences between people. However, the meaning of diversity has been significantly expanded during the past several decades to include all forms of differences (e.g., sexual orientation, gender, language, culture, religion) (Marquardt, 2009). Initially, diverse populations were those that did not belong to the White majority, but gradually, the term came to include all people of other nationalities, colors, and social backgrounds. In this manner, the issue of diversity has become even more complicated, as it requires comprehensive actions and practices to address a great variety of differences and identities.

The concepts of diversity and inclusion have significant organizational implications. In the past 40 years, US organizations have introduced various diversity initiatives—such as practices, policies, and training efforts—to provide equal opportunities in the workplace (Marquardt, 2009). Currently, cultural and racial diversity appears to attract even more attention in the organizational environment because society understands the growing importance of values such as equality, tolerance, and justice. Federal and private corporation initiatives introduced nationwide not only are used to support minorities but also are used to make diversity the central organizational value and goal (Burns, Barton, & Kerby, 2012). Although minority populations continue to encounter apparent challenges when it comes to career opportunities and promotion, one cannot deny the fact that underrepresented people now enjoy greater protection, and that organizations place greater focus on workforce diversity than they did several decades ago.

Workforce diversity is a broad term that can be interpreted differently depending upon the use of the term and the context in which it is used. According to Begeç (2013), researchers who examine diversity within the workforce "define diversity characteristics into four areas: personality (e.g., traits, skills, and abilities), internal characteristics (e.g., gender, race, ethnicity, intelligence, sexual orientation), external characteristics (e.g., culture, nationality, religion, marital or parental status), and organizational characteristics (e.g., position, department, union/nonunion)" (p. 64). Diversity requires introspection in order to understand where commonalities may exist or where there may be individual differences. In the workforce, diversity is the understanding of, acceptance of, and mutual respect for individual differences (Mba & Teresa, 2013). Thus, it is evident that diversity

in the workforce has evolved beyond mere tolerance of the fact that it exists. Organizations now seek ways to embrace and celebrate diversity. Scholars have shifted the focus in research from the single dimension of diversity—focused on age, race, or gender—to a multi-dimensional context in which the combination of age, race, gender, and national origin are important considerations as globalization transforms the work environment (Shore et al., 2009).

Within the workforce, diversity often also has a negative connotation due to its association with discrimination and victimization. However, organizations that have initiatives and interventions that support diversity management understand ways in which diversity can positively influence organizational success and outcomes. Positive outcomes may include information sharing, increased creativity and innovation, higher quality decision-making, and increased understanding of the organization's demographics and culture. According to Shore et al.'s (2009) model, both internal and external factors can influence diversity in organizations and the potential outcomes that are linked to diversity.

Gotsis and Kortezi (2013) contended that organizations must support diversity because morally it is the right thing to do, despite any negative or positive outcomes that the organization may have in supporting diversity initiatives. Gotsis and Kortezi (2013) suggested that, according to the Kantian deontology, majorities in an organization have a duty and obligation to respect the diversity of others. An ethical view of diversity management supports enhancing the wellness of minorities through diversity networks, training programs, and other interventions that can eliminate barriers to career

advancement and personal growth (Gotsis & Kortezi, 2013; Rabl, María del, Seo-Young, & Bosch, 2018).

**Diversity Matters**

The social identity theory can be used to understand the relationship of diversity with team dynamics. According to the social identity theory, homogeneity creates a sense of belonging within an in-group and is a source of self-esteem (Sabharwal, 2014). Individuals prefer to work in homogeneous groups, which are groups in which individuals share a commonality. However, the homogeneity within a group can lead to one group stereotyping or judging others and, in certain cases, discriminating against other groups because of differences. Further, homogeneity aligns with what Irving Janis, a social psychologist, identified as "groupthink" in the 1970s and a debilitating cause for failure in organizations to be innovative (Grensing-Pophal, 1999). Diversity is of significance in the workforce because when diversity is not accepted, those external to the majority (the in-group that holds authority and represents leadership) may have additional barriers to overcome in order to achieve the same level of individual success or to obtain higher levels of leadership and authority (Coleman, 2012; Warden, 1999). McMahon (2010) suggested that there is a growing case for businesses seeking diversity because of a greater selection of talent and a diverse customer base. Hunt, Layton, and Prince (2014) identified that gender-diverse and ethnically diverse organizations are 15% and 35%, respectively, more likely to outperform their peers.

**Advantages of Diversity**

Numerous organizational leaders perceive that diversity can add value to the workplace by enabling greater utilization of talent and encouraging innovation among

team members. According to McMahon (2010), “diversity in business helps in pooling the best talent, reduces the gap between increasing diverse customer bases, unleashes creativity, promotes innovation, and thereby enhances the competitiveness of the organization” (p. 40). Further, Hoffman and Maier (1961) demonstrated that diverse groups could produce higher quality solutions when problems occur that are also more likely to be accepted when compared to solutions from more homogeneous groups.

Diversity among senior management, also referred to as the Top Management Team (TMT), has been shown to have a positive impact on firm performance. In line with findings from Olson et al. (2006), support from CEOs to uphold diversity and their influence on a heterogeneous TMT can be a positive influence on organizational cohesion and the loyalty of members of the TMT, thereby leading to improved strategic choices and performance outcomes. A positive expansion in the external perceptions of an organization are attributable to diversity. Investors consider diversity to be a positive indication of the organization’s direction and future performance (Cunningham, 2009).

An abundant body of literature highlights the advantages of workplace diversity. In a study conducted by Patrick and Kumar (2012), 300 employees in the IT industry were surveyed. The results obtained are evidence that effective diversity management is associated with commitment and improved job satisfaction and financial performance (Patrick & Kumar, 2012). Although this study does not relate to health care treatment, these findings are valuable as a source that supports the apparent advantages of managing diversity issues. Along similar lines, Ordu (2016) argued that comprehensive diversity management could have a positive impact on employee satisfaction and individual performance. Further, Sania, Kalpina, and Javed (2015) found that although diversity was

not related to customer satisfaction, this organizational aspect was directly associated with employee morale. In addition, it is believed that diversity provides opportunities for personal growth because employees are exposed to new perspectives and worldviews.

Increased productivity is another advantage of organizational diversity. In a literature review, Saxena (2014) revealed that when diversity is appropriately managed in the workplace, employees tend to work more productively. He added that despite the proved value of diversity, numerous organizational leaders and employees continue to hold biases concerning minorities (Saxena, 2014). Similarly, Ilmakunnas and Ilmakunnas (2011) investigated the effect of workplace diversity on productivity and found that creativity and communication in a diverse workplace environment contributed to productivity.

Barta, Kleiner, and Neumann (2012) analyzed the findings of an international study that assessed the effects of diversity on organizations. Barta et al. (2012) found that organizations that have diverse executive teams are more high-performing than their less diverse competitors (Barta et al., 2012). More specifically, organizations that include female employees and foreign nationals were more successful in terms of returns on equity (ROE) and earnings before interests and taxes (EBIT) (Barta et al., 2012). The large sample size that includes 180 organizations from four countries makes these findings rather convincing. However, they have indicated that more research is required to determine the relationship between diversity and performance, because it is still unclear how other management approaches and organizational policies affect success (Barta et al., 2012).

In the health care sector, the proponents of matching workforce demographics to patient diversity suggest that increasing diversity will result in increased cultural awareness, reduced discriminatory practices, and the ability to address population needs more effectively (Horwitz, Marilyn, & Horwitz, 2011). Diverse leadership, particularly among physician leaders, can result in improvements in quality care (Horwitz et al., 2011). Diverse health care providers are empowered to address their clients' needs more effectively because they are aware of the problems that are likely encountered by minority populations.

However, as maintained in findings from other studies, diversity does not necessarily lead to improving organizational and employee performance. For example, in a survey by Darwin and Palanisamy (2015), age, gender, and ethnic diversity initiatives were not associated with an impact on employee performance. Darwin and Palanisamy (2015) found that employees were rather indifferent to the values of diversity, which might have affected their response. Although this study was conducted in a setting that was outside the US, inconsistency in findings are indicative of the importance of conducting further research in this area. Moreover, these results are in line with the previous study by Jayne and Dipboye (2004), which revealed that the effect of diversity may be exaggerated and that a multicultural environment may create communication and cohesion problems.

**Disadvantages of Diversity**

The opponents of diversity have many reasons for why they do not support initiatives to drive and encourage heterogeneity. Diversity is added complexity, as individuals belong to diverse backgrounds and different perspectives with respect to how

an organization must operate. Begeç (2013) suggested that diversity and heterogeneous groups can lead to conflict and resistance to change. The complexity that is associated with diversity also comes with added costs for organizations to develop strategies for management. Diversity issues often are identified through "legal policies regarding equal opportunity, affirmative action, and nondiscrimination statutes" (Grant, 2010, p. 41). The costs of managing diversity and the issues that come with it may be financial or non-financial. Costs include increased time to coordinate business processes among diverse groups. Within diverse groups, those that are not in the majority may have problems with psychological commitment, increased employee turnover, and absenteeism (Cunningham, 2009).

When diversity is not managed, tensions among employees rise, information exchange is limited, and there may be poor performance outcomes (Chaurasia & Shukla, 2012). Diverse groups find more difficulty in reaching a consensus in decision-making as compared to homogenous groups (Watson, Kumar, & Michaelsen, 1993). Heterogeneous groups are more likely to have lesser social interactions and may experience deterioration in communication efforts, thereby resulting in turnover among those who are most distant (Cunningham, 2009; O'Reilly, Caldwell, & Barnett, 1989). Further, not managing diversity can result in a workforce where skill sets are not based on competency and where skills and personalities are not complementary (Grensing-Pophal, 1999).

Kunze, Boehm, and Bruch (2013) found that age diversity in organizations can contribute to negative age stereotypes and decreased performance. Kunze et al. (2013) used the social identity and social categorization theory to suggest that organizations with high age diversity risk facing social fragmentation, which in turn affect team performance

(Kunze et al., 2013). Data collected from 147 organizations supported this hypothesis. It has been found that age diversity led to age discrimination, but only in organizations with no effective HR policies. In other words, the levels of age discrimination were lower, while performance was higher in organizations that incorporated diversity-friendly policies and incentives (Kunze et al., 2013).

When diversity initiatives are not appropriately managed, employees may negatively perceive the initiatives, thereby contributing to workplace tension. As discussed in Munyeka's (2014) study, when management fails to inform employees about diversity programs or raise their awareness of the problem, the latter are left dissatisfied and become resistant to changes. Moreover, Munyeka (2104) found that many employees perceived diversity as a threat to organizational stability and working relationships. Only top management staff appeared to hold positive attitudes toward diversity in this study (Munyeka, 2014). These findings are evidence that diversity management is an intricate and complicated process that requires the inclusion and participation of all team members.

Moreover, it must be added that certain employees possess limited knowledge and understanding of diversity. There are significant differences between managers and non-managers in terms of attitudes to workplace diversity. Many factors—such as, for example, educational level and experience abroad—have an essential role in embracing the principles of diversity (Munyeka, 2014). Identifying these factors and predicting their influence on employees' response to diversity initiatives may be challenging.

**Organizational and Industry Constraints**

Organizational constraints have an impact on the relationship between leaders and followers and can either support or serve as a barrier to diversity management programs and initiatives. Rangarajan and Black (2007) suggested that structural, cultural, and semantic barriers are the primary organizational constraints to diversity in the workplace. Structural barriers are factors, like a hiring freeze, that may not relate directly to diversity; however, the consequences may negatively impact the efforts to promote diversity initiatives (Rangarajan & Black, 2007). Rangarajan and Black (2007) stated that "organization's history, communication networks, employee age and tenure, and physical environment contributed to a culture that makes it difficult to integrate diversity" (p. 257).

The sensitivity of race relations within the organization and the lack of experience to manage diverse populations are examples of cultural barriers. Johns (2013) suggested that different styles and behaviors of employees in a diverse climate can be a hindrance. Another cultural barrier cited by Allison (1999) is bureaucratic or institutional inertia, such as no diversity champion, selective hiring, and promotion practices, the lack of communication to staff from leadership, and the failure for diversity initiatives to compete with other budget priorities. Further, Allison (1999) posited societal barriers as an additional barrier, as external factors could influence organizational behaviors.

Another organizational constraint is the lack of support provided to leaders. In this respect, Trenerry, Franklin, and Paradies (2012) argued that leaders might feel limited in their ability to make any positive changes in eliminating institutional racism and discrimination. Leaders often have limited resources for addressing workplace inequality

and cannot affect the situation even if they desire to. In addition, Davis, Frolova, and Callahan (2016) argued that senior managers' attitudes toward diversity could be one more serious barrier to inclusion. These employees may perceive diversity policies as a threat to their career advancement and may resist diversity initiatives even when they realize the benefits of such initiatives for the organization.

The health care industry may be subjected to similar organizational and system constraints that deter inclusion. McDonagh, Bobrowski, Hoss, Paris, and Schulte (2014) argued that men are expected to occupy top leadership roles, while female leaders are perceived stereotypically. McDonagh et al. (2014) noted that although women possess sufficient skills and knowledge to hold higher executive level positions, organizations do not have effective career development, succession training, and leadership training programs and policies to support these employees (McDonagh et al., 2014). There is also a lack of corporate culture incentives that would encourage gender diversity in the workplace and provide more opportunities to women. McDonagh et al. (2014) emphasized that health care providers are still reluctant to embrace transformational and collaborative leadership approaches that would stimulate diversity.

Further, Valentine, Wynn, and McLean (2016) attempted to identify reasons why African Americans, Hispanics, and Native Americans are underrepresented in the US health care industry. Valentine et al. (2016) indicated that discrimination begins as early as at the first stage of academic preparation (Valentine et al., 2016). Systematic inequalities and the lack of support for students from disadvantaged communities prevent talented and hardworking people from obtaining a degree and entering the workforce. Moreover, Valentine et al. (2016) emphasized that minority populations lack awareness

of career opportunities available in the health care sector and do not have mentors who could guide them in this respect. Along similar lines, Iglehart (2014) argued that minority populations do not have the same economic opportunities as other families do when it comes to education and training. Consequently, these people cannot receive the quality education that is necessary to succeed in this industry.

**The Role of Leaders in Promoting Diversity**

Leaders play a central role in promoting and encouraging workplace diversity. Meeussen, Otten, and Phalet (2014) found that leaders' colorblindness and multiculturalism have a positive effect on the workplace environment and the promotion of diversity. Leaders with positive attitudes toward diversity facilitated the functioning of work groups by making employees feel valued and accepted (Meeussen et al., 2014). The findings from their study are indicative of the visions and beliefs of leaders regarding the effect of workplace diversity on team functioning and cohesion.

Similarly, Williams (2013) acknowledged the central role of leaders in promoting diversity and provided several recommendations for leaders to effectively manage diverse teams. First, Williams (2013) noted that leaders working with diverse employees must be aware of the concept of diversity and recognize the importance of inclusion for achieving success. Second, Williams (2013) maintained that leaders must acknowledge their subordinates' diverse identities and teach the team to accept and respect them. Third, leaders can make diversity a central part of the organizational culture, thereby promoting multiculturalism and equality.

Davis et al. (2016) agreed with the latter point and noted that leaders advocate for diversity at both the team and organizational levels. Davis et al. (2016) explained that

leaders are the main driving force when it comes to workplace inclusion (Davis et al., 2016). Leaders can incorporate diversity into the strategies and mission statements of their organizations, thereby contributing to the creation of a favorable corporate culture. Davis et al. (2016) also noted that leaders could contribute to a "climate of openness, equity, tolerance and inclusion" (p. 85) by facilitating employee communication, building effective teams, and promoting honesty and tolerance. Davis et al. (2016) emphasized the extreme importance of internal communication in fostering diversity values. Leaders are expected to facilitate this communication and ongoing employee interaction to eliminate bias and stereotyping and instill the values of equality and acceptance.

In a comprehensive study on the role of leaders in diversity promotion, Cook and Glass (2014c) analyzed data collected from Fortune 500 organizations in the period from 2001 to 2010. Surprisingly, Cook and Glass (2014c) found that minority CEOs have little effect on their organizations' diversity policies. However, greater diversity in boards was a significant factor that contributed to more equal and inclusive practices (Cook & Glass, 2014c). At the same time, organizations having both diverse boards and a minority CEO were less likely to commit to diversity efforts, possibly because they perceived this mission as one that was already fulfilled. Another reason for this lack of diversity focus in such organizations is the fear that any further diversity policies would be perceived as self-serving (Cook & Glass, 2014c). Nevertheless, despite these controversies, the authors highlighted the extreme necessity of supporting minority leaders, as they can impact both diversity policy and practice and serve as role models for minority employees (Cook & Glass, 2014c).

**The National Context**

The diversity of leaders in the top organizations in the US provides a national context for the need for continued efforts to improve diversity. *Fortune*, a business magazine, began publishing rankings of the top 500 US corporations by total annualized revenue, referred to as Fortune 500 companies, in 1955. It was not until 1987 that Dr. Clifton R. Wharton, Jr. became the first African-American to become the CEO of a Fortune 500 company. While efforts that support diversity have increased, less than five percent of Fortune 500 CEOs belong to the minorities (Frankel, 2015). In a study of CEO transitions among Fortune 500 organizations from 1996 to 2010, Cook and Glass (2014b) also demonstrated that "racial/ethnic minority leaders are granted limited opportunities to demonstrate their capabilities" (p. 450). According to the authors, when minorities are placed in a leadership role and organizational performance is suboptimal, White males immediately replace minorities, becoming corporate saviors (Cook & Glass, 2014b).

Recent changes in the highest leadership positions of Fortune 500 companies evidence of the alarmingly low level of diversity. Berman (2015) wrote that after McDonald's CEO Don Thompson left his job, there remained only two Black CEOs in the list of the most successful organizations. Similarly, in 2017, the retirement of CEO Rosalind Brewer signaled the severe underrepresentation of minority women in leadership positions (Brown, 2017). Experts explain that this decreasing racial diversity is due to the changes in corporate policies. More specifically, organizations have focused more on attracting employees from foreign countries, which implies that the interests of local minority populations are ignored (Berman, 2015). Moreover, organizations that

claim to being committed to diversity values often do not have adequate training and recruitment policies to support minority employees.

**Diversity in the Health Care and Insurance Industries**

Minority underrepresentation appears to be present in the health care sector as well. The list of minority executives currently working in the US was recently published in *Modern Healthcare* (2016). While recognizing these peoples' contribution to the development of the industry, this organization highlighted that the sector has been "painfully slow in promoting minorities to senior executive and trustee posts" (Modern Healthcare, 2016, para. 2). An emphasis was placed on the current leadership composition not reflecting the country's demographics. While the number of minority patients steadily increased, minorities occupied only 12% of executive leadership positions (Modern Healthcare, 2016).

According to the report provided by *Modern Healthcare* (2016), the lack of diversity in the health care system prevented providers from delivering quality services. For example, majority employees are not aware of the cultural norms and practices that are embraced by certain minority groups, which implies that they cannot assess their impact on care. According to the experts, it is not sufficient to merely educate White employees on these cultural issues (Modern Healthcare, 2016). There is a strong requirement to instill diversity values at the highest organizational level, where organizational policies and practices are developed (Modern Healthcare, 2016).

Henkel (2016) reflected on the same issues experienced by American health care providers. The author stated that the number of underrepresented racial and ethnic minorities (UREM) in leadership positions is too low. There are only 14% of minority

leaders on the boards of directors of hospitals, and women constitute merely 11% of health care CEOs in the country. These statistics are dismal, given the increasing diversity of American society and the growing number of minority patients (Henkel, 2016). Experts interviewed by the author claimed that more efforts must be made to promote diversity in the health care sector (Henkel, 2016). They argued that inclusion and multiculturalism are the keys to addressing the current problems experienced by providers. Consistent with the argument provided by Valentine et al. (2016), Henkel (2016) maintained that support and promotion of minorities should begin with relevant educational interventions and programs.

Silver (2017) provided insight into the attitudes of health care executives toward diversity. Silver (2017) conducted semi-structured interviews with White and minority leaders to learn about their perceptions of workplace diversity. Both groups of interviewees had positive perceptions of diversity. However, the groups differed slightly on the proposed solutions to address the problem of health care access for minority populations. It seemed that minority interviewees were more aware of the challenges experienced by diverse populations than majority executives were; moreover, these interviewees had a clear understanding of the measures that must be taken to address these problems. Therefore, Silver (2017) suggested that leadership positions must be occupied by representatives of different ethnic, racial, and cultural groups in order to improve health care policies and access as well as deliver more competent care.

The American College of Healthcare Executives (ACHE) acknowledges the role of diversity in driving positive changes in the industry (Dolan, 2013). Diversity, integrity, lifelong learning, and leadership are four central values promoted by this organization. In

order to help providers employ and retain the workforce that could reflect the diverse community, ACHE has developed several innovative programs, such as the Hospital Trustee Professionalism Program and Minority Trustee Candidate Registry (Dolan, 2013). The first program trains potential board members and provides valuable knowledge and skills to apply for leadership positions, whereas the second program focuses on helping these people climb the career ladder (Dolan, 2013). ACHE's efforts directed at promoting diversity reflect the growing understanding that inclusion will play a critical role in the future of the health care industry.

According to Grant (2010), recruitment for management positions in health care organizations reflects the ethnicity of the population that represents the majority rather than a population that comprises multiple ethnic groups. The non-Hispanic White population constitutes the majority of the US population at 62% (Grant, 2010). Analysts expect that minorities will not become the majority until 2044 (Colby & Ortman, 2015). Further, Haynes, Toof, Holmberg, and Bond (2012) state that "gender and ethnic segregation in health care settings are common and increase as one moves up the hierarchy" (p. 166). With an increase in diversity in the general population, the diversity of the workforce within and outside the health care industry must also increase. However, efforts such as undergraduate college programs that support developing diversity talent have not led to a significant change in senior management levels (Matus, 2003).

Witt/Kieffer (2015) conducted a study of 311 health care executives in collaboration with the Asian Healthcare Leaders Association (AHCLA), Association of Hispanic Healthcare Executives (AHHE), Healthcare Businesswomen's Association (HBA), Institute for Diversity in Health Management (IFD), National Association for

Health Services Executives (NAHSE), National Forum for Latino Healthcare Executives (NFLHE), and Rainbow Healthcare Leaders Association (RHLA). Findings from the study illustrated that the majority of Whites (53%) agreed that there was a lack of commitment by top management to diversity in health care organizations, which was reported to be the top barrier to diversity by 85% of the minorities (Witt/Kieffer, 2015). Whites (85%) indicated the lack of access to diverse candidates as the leading barrier. Survey results demonstrated that 83% of the study's participants believe that promoting minorities from within health care organizations was the leading solution for increasing diverse representation (Witt/Kieffer, 2015). Moreover, creating mentoring programs (84% of participants) was identified as the best practice for creating diverse leaders, while only 59% of participants supported leadership training programs (Witt/Kieffer, 2015).

O'Brien and Bobick (2012) suggested that the insurance industry, in particular, has been slow to adopt diversity in leadership because the insularity of the industry has prevented a diverse source of candidates. The authors indicated several factors that contribute to this problem (O'Brien & Bobick, 2012). Because insurance is an industry that mitigates risk, there is an unwillingness to hire candidates who do not have specific experience in the industry versus those who have leadership competencies and leadership potential. In addition, learning is a slow process in the insurance industry compared to other industries like investment banking (O'Brien & Bobick, 2012). Training is a one-dimensional process through shadowing others who perform similar functions instead of more intensive training that leverages the development of an individual's general management skills. However, insurance organizations could visibly address diversity by

employing diverse candidates in infrastructure roles, particularly top executive roles referred to as the C-suite, such as Chief Information Officer and Chief Financial Officer, where skills are transferable.

## Leadership

As previously noted, a strong link exists between leadership and management initiatives on the one hand and workplace diversity on the other. Leadership and diversity management is believed to foster respect, acceptance, and connection within the team; thus, its importance can hardly be overestimated. In this part of the literature review, the researcher focused on the description of diversity leadership and management practices and the identification of their role in leadership promotion of minorities.

### Leadership Advancement

Leadership development is an integral part of human resource and diversity management in any organization, so it is not surprising that organizations spend a significant amount of time, effort, and money on preparing their future leaders (Jin, Lee, & Lee, 2017; Mabey, 2012). As defined by Wilson and Kraus (2014), leadership development includes "formal programs and policies instituted by an organization to improve the quality of leader performance" (p. 3). It is concerned with careful selection, encouragement, and support of employees who possess leadership potential to enable them to occupy higher executive positions and become successful leaders. Initiatives for leadership development can be directed both at nurturing particular skills (e.g., interpersonal, cognitive, business, problem-solving, strategic) or providing practical training that focuses on leadership in general (Wilson & Kraus, 2014). The most common format of leadership development programs is informal off-the-job events, which include

training to employees on vital leadership skills (Packard & Jones, 2015). Ideally, leadership development initiatives facilitate leadership advancement of employees by providing them with essential knowledge and skills.

However, leadership development is a complex process that certain organizations are unable to maintain. It involves a thorough assessment of current needs and processes, selection of target employees, design of infrastructure, effective evaluation methods, and numerous other organizational requirements (Packard & Jones, 2015). In addition, leadership development programs must take into account the social and demographic issues that exist within organizations. When they fail to do so, minority employees may be at a disadvantage because of the lack of resources and empowerment to pursue career advancement, as well as the overall discriminatory atmosphere. According to the estimates provided by Kameny et al. (2013), 72% of minority employees encounter workplace barriers to career advancement, and 26% of people experience gender discrimination.

A significant number of challenges may prevent minorities from leadership advancement when their organizations do not invest in diversity leadership development programs. For example, Kadi (2014) argued that representatives of religious minorities might experience significant barriers to leadership promotion. In Kadi's (2014) study, data was collected from two groups of Muslim Americans (leaders and non-leaders) employed in the legal field. According to the data, both groups experienced barriers to leadership advancement, such as discrimination; lack of training, mentoring, and support; limited opportunities; and pressure from influential leaders. Moreover, the participants felt that there was a lack of understanding between their colleagues and them, which

further complicated the problem. Non-leaders claimed that they lacked leadership experience, which prevented them from pursuing promotion (Kadi, 2014). Further, Almaki, Silong, Idris, and Wahat (2016) added that Muslim women are often subjected to double discrimination because of the stereotypes regarding gender coupled with their religious and cultural norms.

Although barriers to the advancement of minorities may occur at an individual level regardless of race, when the race is a factor, the barriers can be far greater. Common barriers to the advancement of minorities include lack of mentoring, exclusion from organizational networks, stereotyping, and omission from challenging assignments (Kalra, Abel, & Esmail, 2009). According to Kameny et al. (2013), these barriers may be institutional, cultural, or personal. Institutional barriers are informal policies and procedures that lead to the lack of representation of minorities in established leadership positions. These institutional barriers may include reduced organizational efforts and support for policy changes that encourage recruitment and promotion of minorities. Moreover, cultural barriers result from the misconceptions about minorities and their capabilities. These cultural barriers include limiting opportunities to only one minority, often to fill quotas (tokenism), and restricting minorities to specific roles (typecasting). Consequently, as suggested by Kameny et al. (2013), minorities often feel that they have to prove their skills and talents to overcome these misperceptions. Last, the lack of applicable skills and personal characteristics can prevent advancement for anyone in their career. However, personal and skill barriers are often greater for minorities when they are the first generation to advance in their careers and there is a lack of mentors to guide and advise them (Kameny et al., 2013).

Murray (2015) divided all barriers to leadership advancement into institutional and personal ones. The latter include education, experience and expertise, job performance, and applying for jobs. In turn, institutional barriers include promotion decisions, recruiting policies, and access to resources. Murray (2015) found that all employees, irrespective of their background, might experience challenges when it comes to promotion; however, minority employees experience greater problems because of stereotyping, discrimination, and cultural differences (Murray, 2015). In addition, based on study findings, the lack of support from current leaders was a serious problem for all employees. Moreover, the lack of encouragement and leadership development, combined with limited funding, was a serious constraint for those seeking advancement (Murray, 2015).

According to Kay and Gorman (2012), there are three primary reasons why Whites may be selected over minorities for leadership positions. Minorities enter an organization at lower levels in the organization compared to Whites. Factors that contribute to this include fewer effective social networks and disadvantages in educational backgrounds. The authors state that the second reason is attributable to "conscious or unconscious cognitive biases" (Kay & Gorman, 2012, p. 93). Stereotypes may portray minorities as less component and lead to favoritism of Whites over minorities. Therefore, the latter have to demonstrate greater abilities to achieve promotions. Last, Kay and Gorman (2012) suggested that Whites are likely to have better developmental opportunities, such as mentoring, than minorities. The belief is that senior leaders perceive Whites to have more potential than minorities. When minorities do

receive development opportunities, the guidance and support they receive are lesser than that given to Whites (Kay & Gorman, 2012).

**Leadership (Management) Styles**

Businesses are usually established with trusted partners. These partners generally hire others with whom they have established relationships. Often the management style is one of the reasons that certain leaders are put in place over others. However, leaders possess different management styles, just as businesses require different leadership styles depending on business objectives, operations, and other internal or external dynamics. Several leadership styles are commonly identified as positively associated with enhancing the management of diversity, responding to issues of discrimination, and facilitating inclusion and perceptions of social identity groups (Anonymous, 2016). Conversely, other leadership styles, such as autocratic and laissez-faire styles, do not promote inclusion and further highlight a lack of diversity.

Shared leadership, team leadership, leader-member exchange (LMX), and transformational leadership are examples of styles that foster inclusion. Transformational leaders can influence others positively by communicating their vision that supports diversity and inclusion and engages followers in promoting common goals. Wang, Rode, Shi, Luo, and Chen (2013) argued that transformational leadership tends to reduce the adverse effects associated with team diversity. Wang et al. (2013) found that diverse teams where this type of leadership is practiced are more creative and innovative compared to those that employ other leadership styles (Wang et al., 2013). Mitchell et al. (2014) agreed that transformational leadership is indeed effective in diverse teams.

However, the authors noted that while this leadership style enhances cooperation and information-sharing, this effect depends substantially on the environment.

Further, team and shared leadership embraces the diversity of individuals who work together to achieve goals rather than focusing on the attributes of individuals that can challenge goal achievement. Hoch (2014) found that shared leadership practiced in diverse teams facilitated team performance and information sharing. Hoch (2014) demonstrated that the more diverse a team is, the more advantages its members could obtain from sharing leadership responsibilities and communicating with each other. Through the leader-member exchange, leaders seek ways to encourage the inclusion of different members of the organization and, in doing so, can shape the beliefs of others to achieve collective goals. This approach to leading diverse teams can also be effective as it fosters an environment of embracing diversity and positively affects inclusion and job satisfaction (Brimhall, Lizano, & Barak, 2014).

While there are different leadership styles, Van de Ven, Rogers, Bechara, and Kangyong (2008) identified that when leaders adopted an integrative behavior, there was a positive influence on the performance of health care clinics because employees were more open to share information, resolve conflicts, and influence business decisions. There may be conflict due to the different perspectives that result from diversity. However, integrative behavior is a moderator that increases social and psychological safety, thereby resulting in more creative problem-solving and effective decision-making (Van de Ven et al., 2008).

**Training Leaders on Diversity**

Leaders often support diversity initiatives in order to fulfill legislative requirements, such as affirmative action and equal opportunity laws. They also support diversity initiatives to mitigate potential discrimination lawsuits. However, diversity in health care leadership is often non-existent because organizations hire and recruit staff that resembles the existing staff rather than the diversity of the constituents they serve (Grant, 2010). When the hiring of minorities is incorporated into the hiring practices of the organization, the roles filled are usually in support positions rather than in management positions (Grant, 2010).

Diversity, or cross-cultural training, is a part of many diversity management programs. These programs equip leaders and managers with knowledge regarding differences in cultures and identities that may affect the organizational environment. However, Hiranandani (2012) warned that cross-cultural training runs the risk of stereotyping cultures when conducted by White majorities. The problem is that, in such situations, education often comes down to customs and traditions, ignoring the lived experiences of minority populations and preventing them from expressing themselves. Therefore, careful consideration must be given to cross-cultural training to ensure that the colleagues of minorities understand minorities' needs, interests, and perspectives.

Further, the inclusion of diversity training for management must be a part of the organizational business strategy and the diversity communication strategy designed by leadership for the entire organization (Gündemir et al., 2017; Warden, 1999). This combined approach offers an approach to address both individual and organizational contexts. Algahtani (2013) also suggested that effectively managing diversity requires

"socializing diversity" throughout the organization, beginning with leadership. Socializing diversity is the popular transformational approach to diversity management, which is a more strategic approach when compared to liberal and radical change approaches to train entire organizations simultaneously.

Leaders must be educated on the diversity of their organization's workforce in order to be accountable for improving diversity in organizations (Grant, 2010). In health care, leaders must be made aware of the diversity of community members to enable change. Only 6% of CEOs are minorities, while minorities account for 60% of disparities in quality of care (Grant, 2010). Grant (2010) suggested that if the same existing practices of hiring and educating leaders continued, disparities in quality of care for minorities and poor populations that are underserved would remain.

## Diversity Management

Diversity management is an integral part of the corporate initiatives and policies in both public and private organizations. As explained by Sharma (2016), diversity management is aimed at addressing the needs and interests of diverse groups of employees to avoid workplace tensions and conflicts. It focuses on maintaining harmony among team members as the primary driver of productivity and ongoing organizational development. Further, Sharma (2106) highlighted the necessity of distinguishing between diversity management and equal opportunities. The latter term refers to the policy of tolerance that promotes minorities in leadership. However, diversity management is focused both on accepting differences and practicing non-discriminatory and respectful attitudes to all employees, irrespective of their background (Sharma, 2016).

It must be noted that diversity management in any organization has certain basic requirements. The first step is to assess diversity issues in the organization and consider how these issues are currently addressed by the organization. When the organizational culture and employees' perceptions are carefully evaluated, managers and human resource professionals can develop relevant interventions. Irrespective of the situation, it is important for managers and leaders to facilitate and encourage participation, teamwork, and cohesiveness (Sharma, 2016). The selection of an approach to equality and diversity management is another key step, which depends on, among other factors, the organizational structure, setting, and team composition.

Organizations are willing to support community programs because such programs demonstrate an organization's commitment to social responsibility; however, internally organizations fail to develop an adequate plan for diversity (Warden, 1999). Human resource departments may be tasked with implementing initiatives to manage diversity and resolve conflicts among various heterogeneous groups within an organization. Diversity management aims to reconcile differences between various groups and encourages individuals to develop greater respect and appreciation for their differences. Effective diversity management requires understanding the value and belief systems that drive individuals to unify in homogeneous groups (Begeç, 2013). Warden (1999) recommended that this include evaluating the "demographics represented in the governance of the organization" (p. 422).

When diverse groups can participate in active debates and open dialogue, diversity enables groups to reach their full potential. When organizations adopt strategic approaches to diversity, potential barriers to the advancement of minorities can be lifted.

For example, in the nursing field, Smith, Turner, Osei-Kofi, and Richards (2004) identified that predominantly White organizations hired minorities when the job description or hiring strategy focused on diversity or when the search committee itself was diverse.

The diversity of a group is likely to bring in a multitude of experiences, backgrounds, and exposure to a variety of cultural issues that can be positive. Cunningham (2009) suggested that there are four leading diversity management strategies: compliance, non-compliance, reactive, and proactive. Organizations with proactive diversity management strategies incorporate diversity into the mission and vision of the organization and place diverse individuals in decision-making positions (Cunningham, 2009).

As Coleman (2012) discussed, diversity in management is a prevalent issue in the US and many other Western countries, as leadership is often represented by heterosexual, middle-class, and middle-aged White males rather than those that are characteristic of the composition of society's demographics. Minorities encounter barriers to advancement in leadership, inequality in compensation when climbing the corporate ladder, and are under greater scrutiny when advancing (Hill, Upadhyay, & Beekun, 2015). Because CEOs are predominately White males, Hill et al. (2015) posit that minorities are perceived as going against expectations when placed in the CEO position.

Although diversity itself does not increase organizational effectiveness, how an organization leverages the experiences of a diverse group can impact organizational performance (Thomas & Robin, 1996). Diversity in management can result in employees recognizing and accepting differences in emotional characteristics, interests, physical

characteristics, and values. However, Thomas and Robin (1996) found that increasing diversity in management also can lead to criticism, as some people believe that diversity brings on new variables or cultural sensitivity that is otherwise associated with organizational projects.

Indications of organizational diversity issues include manager uncertainty and experience in diversity management, which is particularly problematic in the health care industry (Irizarry & Gallant, 2006). In a study of New York hospitals, Aries (2004) identified that diversity management did not always occur uniformly at various management and staff levels of hospitals. Diversity proved to take on more implications and consequences among lower-level managers and staff. Moreover, senior leadership viewed diversity as an environmental issue. In most organizations, senior leaders are responsible for making the ultimate decision on investments in diversity management interventions. However, diversity management interventions may fail to go down to line manager and staff levels. In the study, individual managers determined how to implement diversity practices independently. Different perceptions of diversity led to inconsistencies in addressing diversity issues, ultimately creating a negative patient experience. As such, Aries (2004) recommended that active engagement on diversity must occur at all levels of the organization, including that of health care managers.

Although numerous organizations across the United States have introduced various diversity management initiatives, such as mentoring or training, these initiatives have not yielded expected results (Mazur, 2012). The main reason for this is that managers choose the assimilation approach to address differences among employees. Consequently, minorities are not recognized and valued and cannot perform successfully

in a hostile organizational environment. Thus, there is a strong need to embrace the inclusionary approach, which focuses on appreciating and using differences rather than attempting to eliminate them (Mazur, 2012). Diversity management must aim at taking advantage of different worldviews, perspectives, beliefs, and ideas and foster each employee's unique identity.

**Affinity or Employee Resource Groups**

Business re-engineering and the implementation of new and innovative programs often require the involvement of all employees in an organization. One method to encourage the engagement of all employees is the creation of affinity groups. Affinity groups, also commonly referred to as network groups or employee resource groups, are formally established groups of employees who are unified by similar underrepresented demographic characteristics, such as gender, minority group, or sexual orientation (Friedman & Holtom, 2002). Affinity groups go beyond advocacy efforts. These groups engage in activities that promote community involvement, educate members about other backgrounds in the organization, offer support to address work challenges, and encourage career advancement. Affinity groups also occasionally bring in leaders in the organization and outside speakers to discuss a variety of topics, such as career advancement and financial planning. An advantage of affinity groups is the ability to develop more personal relationships with others in the organization by identifying a commonality. Friedman and Holtom (2002) also suggested that involvement in affinity groups can result in positive benefits, such as gaining a mentor, which often leads to increased career optimism.

DiversityInc (2012b) provided a list of advantages of affinity groups for organizations that have them. First, these groups can be used to seek and recruit new employees. Affinity group members can visit various events and job fairs as well as promote their work among friends, thereby meeting potential employees and improving the company's reputation. Second, affinity groups positively affect retention because their members feel more commitment and connectedness to the company as compared to employees belonging to minority groups who lack group support. Third, these groups can find and develop talented individuals who would otherwise not be able to build successful careers. Finally, affinity groups also can be responsible for community and market outreach, which is critical for the long-term success of an organization (DiversityInc, 2012b).

Randy (2014) claimed that organizations could utilize affinity groups to facilitate inclusion and diversity. The author argued that whereas in the past these groups were formed mainly as a reaction to discrimination and marginalization, in the current scenario, they may be used to benefit the entire organization. Employee resource groups now serve as a platform to build strategic relationships, impart new skills, pursue collaborative learning, and so on (Randy, 2014). These activities can help strengthen the organization and achieve better employee interaction and performance.

Goode and Dixon (2016) claimed that employee resource groups, among other things, help new employees to get used to an unfamiliar workplace environment. The authors noted that representatives of underrepresented groups often experience difficulties in the initial days of employment. Employee resource groups can help such workers to adjust to the new setting and feel a sense of belonging. It is easier for a new

employee to integrate when he or she gains support and respect from co-workers (Goode & Dixon, 2016). Goode and Dixon (2016) added that resource groups could be effective in looking for new talents and identifying gaps in the current recruitment policies.

Lambertz-Berndt (2016) discussed affinity groups in detail. To begin with, Lambertz-Berndt (2016) explained that affinity groups have two primary purposes—emotional and instrumental. They serve as platforms not only for discussing sensitive topics but also achieving certain specific goals, such as information sharing, skills building, and leadership advancement. According to data collected from 220 respondents, affinity groups were generally perceived positively by employees. Interviewees believed that affinity groups were helpful in establishing friendly relationships with colleagues and constructing one's identity (Lambertz-Berndt, 2016). However, some of them were not satisfied with the timing of group meetings or argued that affinity groups make them feel uncomfortable. It appears that certain employees still associate them with discrimination and oppression, whereas others do not like being reminded of their disadvantaged social and workplace positions (Lambertz-Berndt, 2016).

In addition, Lambertz-Berndt (2016) found that affinity groups often fail to empower minority employees or provide a meaningful discussion of pressing issues. Participants confided that they wanted to feel support and confidence when they visited affinity events; however, they felt confused instead because of the limited opportunities to speak up. Moreover, a few interviewees noted that increasing the heterogeneity of affinity groups would be beneficial both for White employees and those belonging to minority groups, as it would allow them to learn about other peoples' perspectives on diversity and identity issues (Lambertz-Berndt, 2016). Thus, as is evident, affinity groups

can serve as a powerful tool for diversity promotion; however, organizations must ensure that they provide valuable experiences to all employees involved.

**Mentoring**

Mentoring may be a significant factor in leadership advancement. Sharma and Freeman (2014) noted that mentoring is critically important for the success and advancement of employees who are less likely to be promoted to senior and leadership positions, such as ethnic and racial minorities or women. According to Kalra et al. (2009), multiple mentors can assist with advancements in senior leadership roles more than a single mentor. Conversely, "the lack of diverse role models and leaders in influential positions invariably leads to a lack of mentoring or sponsorship opportunities" (Kalra et al., 2009, p. 109). Rich (2013) suggested that a lack of role models may cause two problems that prevent diversity in leadership talent. First, without role models, minorities may not be motivated to pursue leadership positions despite possessing the adequate skills. Second, "mainstream leadership may feel that talented minorities do not apply themselves to achieving their leadership potential" (Rich, 2013, p. 270).

Steele, Fisman, and Davidson (2012) assessed the effectiveness of mentorship program development in the medical profession. Steele et al. (2012) used focus groups, questionnaires, and interviews to collect data on participants' perceptions of this leadership development approach. Results from the study indicated that people having role models were more committed to their careers. Interestingly, it was found that female workers preferred mentors of a similar age who spoke the same language. Moreover, males and females differed in terms of what they looked for in mentors. Male employees

were found to be more concerned with financial issues, whereas women were found to be seeking advice on work-life balance (Steele et al., 2012).

Both mentoring and diversity training positively affect employees by facilitating cohesion and group performance (Gündemir et al., 2017; Law, 2012). According to the with results from surveys in Gündemir et al. (2017) and Law (2012), interventions resulted in improved understanding of diversity and its benefits as well as enhanced personal accountability. Interventions are also associated with stronger work group effectiveness, but only when organizations managed to invest substantial time and effort to include all employees. Law (2012) indicated that it is critical to involve employees, supervisors, and organizational leaders because interventions initiated at the bottom rarely bring long-term results. In addition, it was argued in Law's (2012) study that mentoring programs must be focused on all employees, regardless of their background, to provide equal support to all team members.

Mentoring has multiple advantages for organizations, as argued by Dobbin and Kalev (2016). These programs help reduce managers' bias with regard to their subordinates because they build friendly relationships with them while mentoring. Naturally, a person who invests a lot of time and effort in training and supporting his/her protégés would have a lot of confidence and faith in those individuals (Dobbin & Kalev, 2016). Moreover, mentoring opens new opportunities for minorities. In organizations that employ this diversity management approach, the number of minority employees who occupy managerial positions is higher. Interestingly, Dobbin and Kalev (2016) identified a few differences among men and women with respect to attitudes toward mentoring. More specifically, the conclusion was that men were more likely to find mentors

independently, whereas women preferred using formal programs (Dobbin & Kalev, 2016).

Conboy and Kelly (2016) agreed with Dobbin and Kalev (2016) that mentoring programs are indeed advantageous and added that they facilitate the retention and advancement of minorities. Conboy and Kelly (2016) noted that mentoring is an excellent tool for reducing bias and stereotyping that create barriers to promotion. The participation of top management in the mentoring process is more likely to help minority employees be positively perceived and, consequently, be promoted to higher positions. Mentoring is also beneficial for organizational stability, because minority employees who feel empowered and supported are more likely to remain in the same organization for a long time (Conboy & Kelly, 2016).

When minorities undergo mentoring from White people, they receive less guidance and support than if the mentoring is provided by a mentor who belongs to the same race (Kay & Gorman, 2012). When minority managers do not have mentors, they must take on the role of a sponsor to guide their career path and performance. Kalra et al. (2009) suggested that organizations must recognize diversity in succession planning when there is a lack of diversity in mentoring.

According to Kogler, Hill, and Gant (2000), minorities can use mentoring programs to assist with career advancement. Mentees are more likely to be promoted, earn more money, have a career plan, and remain with the organization as compared to their counterparts who do not have mentors (Williams et al., 2014). However, mentoring programs may not be effective in resolving long-term systemic issues because instead of

removing the obstacles in addressing diversity issues, they enable individuals to navigate around obstacles (Williams et al., 2014).

In a three-year study of minority and White professionals in three American organizations, Thomas (2001) concluded that minorities must be mentored differently than Whites. Thomas (2001) identified that White executives were fast-tracked for advancement in earlier stages of their careers compared to minorities. Mentoring regardless of race was an intervening factor for advancing into executive positions instead of plateauing at middle management positions. Thomas (2001) suggested that mentoring helps to build confidence, competence, and credibility in the early stages of a career. However, richer developmental mentoring offers more personal connection and sponsorship between the mentor and mentee, thereby resulting in better career navigation compared to basic instructional mentoring. In the study, Whites experienced richer, more developmental mentoring at earlier stages as compared to minorities (Thomas, 2001). Further, Thomas (2001) identified that basic instructional mentoring resulted in discouragement, demotivation, and a plateauing of the careers of minorities as compared to those who received richer developmental mentoring.

**Diversity Training and Development Programs**

Between the 1980s and late 1990s, the volume of diversity training in the US increased from being non-existing in most organizations to over 50% of firms having diversity training as a core component of their diversity management programs (Jackson, Joshi, & Erhardt, 2003). Diversity training efforts often grew out of the need to meet compliance with affirmative action or equal employment opportunity laws (Combs, 2002). While a growing number of organizations focus on increasing diversity initiatives,

as few as 16% of organizations have separate budgets for diversity training (McGrory, 2011).

Diversity training leads to increased self-awareness among individuals about their feelings on diversity, such as their biases and fears, which is a key step towards changing behaviors (Gündemir et al., 2017). Diversity training initiatives often only achieve a short-term change in behaviors and attitudes (Combs, 2002). Jackson et al. (2003) suggested that organizations prefer to seek change through the adoption of policies in a more organizational context. Organizations view diversity training as a means to communicate legal issues associated with diversity; individuals are not provided with the ability to learn and apply new skills through diversity training itself.

Further, diversity training must be designed effectively. Poor diversity training can lead to increased levels of differential treatment when there is a lack of follow-up and support. When training occurs after adverse events or is administered only as a one-time practice rather than an ongoing one, employees may feel that diversity training is merely a process rather than a part of the organization's culture (Hite & McDonald, 2006). Consequently, training may further have the impact of dividing diverse groups.

However, diversity training cannot be eliminated because education forms the base of understanding (Combs, 2002). Grant (2010) also suggested that diversity training must include learning from different perspectives in order to enrich the learning experience. In addition, McMahon (2010) recommended that organizations take into account situational factors—such as organizational cultures, strategies, and environment contact—and setting goals to drive the success of diversity programs.

According to a study by Dobbin and Kalev (2016), diversity training must not be mandatory in organizations. Dobbin and Kalev (2016) found that when organizations make their employees participate in diversity programs against their will, training hurts the organizational culture and coherence. Dobbin and Kalev (2016) emphasized that people have a natural tendency to reject any additional training and learning when they do not see their value in the career. It is useless to punish them for not wanting to engage, because negative motivation is not the correct path to success (Dobbin & Kalev, 2016). Therefore, it is essential to ensure that employees are aware of the potential advantages of diversity training and development for all team members and that they are willing to commit to changes.

Diversity training and development is aimed at achieving two objectives. The first objective is to create awareness of diversity within the organization and the organization's environment. The actions taken serve to eliminate biases and stereotypes that may ultimately impact the organization's performance and compliance with regulatory requirements against discrimination. The second objective is to enhance the skills and competencies of minorities and others not considered part of the majority. However, when training is directed toward one group of individuals over others, minorities could become more isolated and negative stereotyping could continue to persist (Kalra et al., 2009).

Alhejji, Garavan, Carbery, O'Brien, and McGuire (2016) conducted a systematic literature review and found that diversity training is beneficial in many ways. From the resource-based view (RBV), organizations can use this type of diversity management to sustain a competitive advantage by using human resources more productively.

Organizations can emphasize the role of diversity training to enhance profitability, customer satisfaction, and sales performance (Alhejji et al., 2016). From a behavioral perspective, diversity training has a positive effect on employees' behavior, thereby making them more confident and effective in dealing with their everyday duties (Alhejji et al., 2016). From the social justice perspective, this training can be used to help eliminate discrimination and inequality, thereby achieving a harmonious workplace environment characterized by tolerance and fairness (Alhejji et al., 2016).

Leaders are valued within organizations and may be perceived as limited resources; therefore, the resource dependency theory may be employed to access resources external to the core business functions. According to this theory, organizations must seek ways to reduce uncertainty, which includes developing leaders from within the organization and avoid or reduce the need for seeking leaders and talent from outside the organization (Thompson & Temple, 2015). Leadership development programs are commonly viewed as formally structured organizational activities or initiatives that may include mentoring, coaching, experimental learning, and providing 360-degree feedback. These programs enhance and develop the knowledge, skills, and competencies of leaders and managers to handle the complexities of internal and external environments (to the organization) on a variety of topics.

Leadership development programs must not only be leveraged as a means to find and retain talent, but they can also be used to motivate individual employees. According to the motivational theory, individuals pursue their needs, which include personal growth and career advancement (Thompson & Temple, 2015). In turn, organization use this personal pursuit to provide job satisfaction and ensure retention. Naturally, employees

who believe that their efforts and hard work will be paid off and valued by their managers are more likely to set ambitious goals. They are more confident in climbing the career ladder and are more likely to succeed when diversity training is introduced in their workplace.

Further, organizations use leadership training and development programs as a tool to remain competitive and to support succession planning (Thompson & Temple, 2015; Narayana, 2013). Leaders are increasingly focusing on improving profitability following the impact of the Great Recession of 2009 and increasing operational cost pressures, such as the passage of the Patient Protection and Accountable Care Act of 2010 (PPACA) and its requirements to provide health care coverage to most employees. Organizations value leadership training and development programs because these programs have been shown to be effective in developing leaders across industries (McAlearney & Sinioris, 2010). Investments in leadership development programs have increased by 14% from 2012 to 2013, totaling over $15.5 billion annually (O'Leonard & Krider, 2014).

According to Armstrong and Ashraf (2011), "integrative thinking is the ability to face the tension between opposing models so that we do not pick one but we generate a creative resolution or model" (p. 271). However, organizational practitioners do not adopt an integrative thinking approach that recognizes diversity as a critical component of leadership development programs or the important impact that diversity training in leadership development may have on business performance and improvement of diversity. Instead, leadership development programs and diversity initiatives often operate separately or they may not occur at all. Cunningham (2009) suggested "effective diversity-management strategies are management oriented" (p. 1448). As such, leaders

must endorse diversity and lead the organization to adopt diversity in the organization's mission, vision, policies, procedures, and ultimately its culture. Diversity management is an elusive concept, but when addressed appropriately, it can make a significant difference in organizations with minority employees.

## Summary

Research gaps that need to be filled were identified in the Chapter 2 literature review. The first and most important limitation of the current literature is that it focuses disproportionately on the clinical health care setting. However, information on the organizational environment of health care insurance is minimal. No relevant reliable empirical studies that focused on investigating the role of diversity in the industry's success could be identified from the literature review. It also remains unknown how leadership and management initiatives that address diversity affect minorities' experiences in health care insurance organizations. Further, a clear gap was identified with regard to whether current diversity management interventions are effective in the leadership advancement of minorities in the health care insurance industry or if certain diversity management interventions were more successful than others. More research is needed to fill this gap and determine how the leadership prospects of minority employees are mediated by diversity management interventions.

In accordance with findings from the literature search, minorities experience numerous barriers to leadership advancement. Various perspectives on diversity in the studies that were analyzed indicated that the advantages of maintaining diversity outweigh the disadvantages. Affinity groups, mentoring, and training and development were identified as the primary diversity management interventions to assist minorities in

leadership advancement. In this study, the researcher used a quantitative correlational design to investigate the relationship between diversity management interventions and the leadership advancement of minorities in health care insurance organizations. Chapter 3 contains an overview of the research methodology used in this current quantitative study.

# Chapter 3

## Methodology

Chapter 3 is dedicated to providing highlights and explanations of key methodological aspects that underpin the overall research process and procedures selected to fulfill the purpose of this research. The research problem, questions, and hypotheses formulated in this study are restated at the beginning of the chapter. This is followed by a discussion on the different research philosophies and philosophic worldview for this study; thereby justifying the choice of the research objective pursued in this study. Then, the different research methodologies rooted in two contrasting philosophic worldviews are reviewed. Following the substantiation of the research method, an overview of the research method and design, population, sample, data collection instruments, validity, and reliability of the study is provided.

### Restatement of the Problem

In the modern globalized world, the movement of people across different parts of the world has become a major tendency that forces changes in the national demographics of the US and other developed countries. The continuing increase in the minority population strengthens the role played by minority people in the national workforce, thereby affecting both private and public sectors, which are expected to adjust to this increase (Harnik, 2016). Although health care is a dynamic industry committed to keeping pace with emerging trends and scientific accomplishments, it lacks representation of minority populations in its workforce. According to the survey findings of the American Hospital Association's Health Research & Educational Trust (2016), minorities lack access to management leadership positions in American hospitals. To be

more precise, the percentage of minority individuals in top- and mid-level management is 17% while that in executive leadership is 12% (Jayanthi, 2016). This statistic is indicative of the preserved domination of the majority in the health care industry. Consequently, the minority workforce is doomed to employee positions only, which deprives them of the possibility of growing and developing in the professional field. The focus of this study's specific problem was the unknown perceptions of minorities of the relationship between diversity management interventions and leadership advancement of minorities in health care insurance organizations.

The claimed ethnic and racial inequality in health care employment produces a negative impact on the entire health care system. Globalization proclaims diversity and cultural sensitivity as the core values of the modern international community (Dumbravă, 2016; Kim, 1999; Zayani, 2011). In health care, these principles require acceptance of patients from different cultural backgrounds and adjustment of care services rendered to meet the needs of all patients. In the context of the underrepresented minorities in the top management and leadership in health care, care services remain focused on the majority population. Stereotyping and discrimination result from the lack of concern for minorities among those on the board (DiversityInc, 2012a). In addition, clinical staff is often unable to understand and comprehend the specific needs of minority patients, whose perception of health and health care are shaped culturally. Moreover, language and social barriers are crucial for the quality of health care services provided to minorities (DiversityInc, 2012a).

While individual nurses or other clinical staff being members of a particular minority community can help build productive communication and collaboration with

minority patients, the system as a whole lacks consideration of the challenges and problems experienced by minorities when accessing a health care institution led by members of the majority (Health Research & Educational Trust, 2016). Apart from health-related disadvantages, poorly addressing diversity and cultural acceptance at the level of the top management results in leadership that is dominated by the majority, which is unable to organize and structure efficient performance of the diversified labor force. The outcomes of such health care management practices include employee dissatisfaction and poor performance, high employee turnover, and low organizational profitability (Kim et al., 2012; Richard, 2000). Minority employees who possess rigor, talent, and skills to contribute to the performance of medical facilities and the health care industry at large typically are subject to inequality, intolerance, and discrimination. Such unfavorable conditions cause a lack of professional development and commitment to performance excellence among health care personnel who belong to the minority status.

The existing scholarship on leadership lacked concern for diversity and cultural sensitivity as well. The core focus of leadership research was either on the required traits, displayed behavior patterns, practiced leadership styles, or the exercise of power and influence. Hence, none of the leadership theories addressed the issue of diversity, which constituted the current social realm. As a result, traditional leadership paradigms had no room for minorities in their roles of, preparation for, and performance in leadership positions (Chin, 2010; Eagly & Chin, 2010). Given the evidence cited above, it was essential to examine whether specific diversity management interventions are likely to affect the leadership advancement of minority populations, thus laying the ground for successful interventions and best practices in health care.

The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the US. Organizations support leadership development programs as opportunities for employee advancement and as internal resource investments toward improvement in organizational performance and long-term sustainability. Organizations also implement diversity initiatives to assist with meeting regulatory requirements, creating a diverse workforce, and managing increasingly diverse work environments. However, little research existed to understand if certain diversity management interventions are more successful than others in achieving advancement for minorities. Additional research in this area could assist organizational practitioners seeking solutions for increased diversity in leadership.

## Research Questions and Hypotheses

The following research questions, aligned with the research purpose, governed the study:

1. Is there a relationship between the perception of minorities about diversity management interventions and leadership advancement of minorities in health care insurance organizations?
2. Which of the three types of diversity management interventions (affinity groups, mentoring, and training and development) have a greater relationship with the leadership advancement of minorities?
3. To what degree do minorities perceive that there are promotional opportunities available to them?

4. To what degree do minorities perceive that they have an understanding of how to advance in leadership?

This study was aimed at investigating the relationship between the perceptions of diversity management intervention and the perceived leadership advancement of minorities to outline areas for improvement and development of long-term strategies for increasing the access of minorities to leadership positions in the health care industry. In line with findings from the observed literature, affinity groups, mentoring, and training and development are drivers of leadership advancement of minorities. In this respect, the relationships between these perceptions of diversity management interventions and the perceived leadership advancement were subjected to further testing. The following null and alternative hypotheses were proposed in this regard:

$H1_0$: There is no significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations.

$H1_A$: There is a significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations.

$H2_0$: There is no significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations.

$H2_A$: There is a significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations.

$H3_0$: There is no significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations.

$H3_A$: There is a significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations.

The first research question was to understand the extent of the relationship between diversity management interventions and diversity in management. The second question was to understand the extent to which one of the three specific types of diversity management interventions may have more influence on the advancement of minorities. The third and fourth research questions were to understand minority perceptions of promotional opportunities to understand whether perceptions may impact the decision to participate in diversity management interventions.

## Research Philosophy

The research philosophy or paradigm is the fundamental aspect of any research, as it is accountable for the researcher's viewpoint and perception of a given research problem. As such, the research philosophy may be recognized as the process of an individual's knowledge acquisition in the pursuit of comprehending particular issues or resolving problems (Phillips, 2014). The ultimate purpose of this philosophic process is to improve the understanding of the world and social reality. Research philosophy underpins the relationship established between the researcher's perception and description of reality and knowledge acquired and accumulated during the investigation of reality (Durand & Chantler, 2014). Therefore, the individual perception and

understanding of the world and its phenomena allow researchers to shape their values and ideas, which, in turn, are an outline for the form and reality of conveying an inquiry. Research philosophy allows for establishing the foundation for further selection of the research approach, strategy, method, and procedures to govern the overall research process (Mora, 2012). Hence, understanding of the experienced research problem and selection of an appropriate research philosophy constitute the primary stage in each academic endeavor.

Two major research philosophies that determine the researcher's position in the inquiry are distinguished in existing literature—positivism and constructivism (interpretivism). Researchers use the positivist philosophy to represent and clarify naive reality observed with the discernibility of its originality (Fox, Gouthro, Morakabati, & Brackstone, 2014). The given social phenomenon is subject to an objective investigation, regardless of its relationship with social actors (Fox, Gouthro, Morakabati, & Brackstone, 2014). When utilizing a positivist research position, a researcher intends to seek consistencies and casual associations within a given matter, following a deductive approach to accomplish the objectives of the study. Positivism is referred to as the universal rules and principles intended to assume and examine cause-and-effect relationships between distinct components of the phenomenon or events in the studied reality (Fox, Gouthro, Morakabati, & Brackstone, 2014). Within positivist research, the development and testing of hypotheses in an experimental and manipulative manner are implied (Sheldon, Davies, & Howells, 2012). Moreover, quantitative methods are used in positivist research to verify the formulated hypotheses through testing various facts, measuring associations, producing statistical results, and presenting general statements.

The ultimate purpose of positivist research is to contribute to existing theory and develop it further.

In contrast, interpretivists view the world and its phenomena in an entirely different manner. The core premise that underpins the constructivist research philosophy concerns the virtual reality that is construed by the human mind over a lifetime. Individual constructs are subject to sharing and exchange through social discourse, which facilitates the development of a common meaning of a particular phenomenon by a given community of individuals (Mora, 2012). In this regard, through the constructivist philosophy, reality is reviewed through economic, cultural, and socio-political perspectives to produce a comprehensive definition of a social phenomenon (Creswell, 2014).

While positivist research is built upon existing theories to study a phenomenon, constructivist research includes the use of theories to explore and describe human behavior patterns examined through a direct interaction between the researcher and the studied reality (Bachman & Schutt, 2014). The positivist research philosophy entails identification and investigation of measurable matters (variables) to determine the nature and level of association among these variables to explain a given reality. On the other hand, the constructivist research philosophy is based on the premise that one can use their human mind to construe social reality by analyzing and sharing individual experiences as well as observations and perceptions of various world phenomena (Schoja, 2016).

Between these two philosophic extremes, scholars distinguish two intermediate positions that combine certain features of positivism and constructivism. These two positions are referred to as realism and pragmatism. Realism is the examination of

external reality by measuring associations between different phenomena (Westphal, 2014). Realism is susceptible to the influence of the researcher's lived experiences, upbringing, and worldviews, which implies that the researcher's personality may impact the findings (Westphal, 2014). Pragmatism includes both positivism and constructivism as the researcher plans and conducts an inquiry and interprets results (Schoja, 2016).

**Research Approach, Ontology, Axiology, and Methodology**

As an overarching concept, research philosophy encompasses research approach, ontology, axiology, and methodology. Research science distinguishes deductive and inductive research approaches, objective and subjective ontology, value-free and value-laden axiology, and quantitative and qualitative research methodologies (Schoja, 2016). Positivism is characterized by deductive reasoning that relies on the facts stated by general knowledge and universal laws formed from empirical research. With regard to general statements, the deductive approach implies an assumption of dependencies and associations between distinct phenomena or components within a single phenomenon (Evans, 2013). Through the investigation of suggested relationships, deductive reasoning conveys experiments and interventions to generate specific findings that highlight a new aspect of the existing theory. While deductive reasoning facilitates explanation, inductive reasoning presupposes exploration and description of a given reality. Therefore, the inductive approach observes and studies specific behavior patterns, cases, or events to obtain insight into the phenomenon and collect detailed data on it (Shepherd, 2015). Inductive reasoning facilitates flexibility of the research process, thereby allowing themes to emerge for further conclusions.

As another determinant of research philosophy, ontology takes into account the nature of reality to attribute either objective or subjective roles to social actors. Objectivism and subjectivism present two dimensions of research ontology. Objectivism promotes the independence of the study's phenomenon from social actors. Conversely, subjectivism claims a reciprocal relationship between social actors and world phenomena (Gabriel, 2015). Therefore, objective ontology examines reality in compliance with universal rules and principles, regardless of human activities. Subjective ontology focuses on various interactions between social actors that are believed to create social phenomena (Schoja, 2016).

Similar to other components of research philosophy, axiology is associated with two different paradigms. In value-free axiology, the researcher has an independent position in data collection and analysis. The objectivity of the research process and findings is ensured through the independent position. Conversely, according to value-bound axiology of constructivist research, the investigator is placed within the studied context as an integral part of reality, which explains the subjectivity of research findings and conclusions (Li, 2015).

The final domain of research philosophy is methodology, which falls within the quantitative-qualitative equilibrium. Following the positivist research philosophy and under the quantitative methodology, reality is viewed and investigated in an objective manner utilizing deductive reasoning. Quantitative research is explanatory, with a focus on defining and measuring variables. Experiments and surveys are the most common methods of quantitative research that serve to collect numerical data across large-scale samples and process results using analytical tools and statistical software (McNabb,

2015). In contrast, through the qualitative research methodology, reality is viewed subjectively and inductive reasoning is used for its exploration and description. In this respect, qualitative researchers prioritize the context of the given social phenomenon to gain insight into its existence and occurrence. This naturalistic approach to qualitative research entails a collection of non-numerical, yet detailed, data through the researcher's direct involvement in the studied reality. Interviews, case studies, observations, grounded theory, narrative, and ethnographic study are common means of qualitative research that minimizes the focus on sample size in favor of depth of information (Merriam & Tisdell, 2015).

Conversely, quantitative research includes an outline of the study's theoretical position, formulates hypotheses, and defines variables to proceed to the fulfillment of the different stages of research design, which includes measuring concepts, determining a research site and sample size, and selecting an instrument (Creswell, 2014). By administering the instrument to the sample, quantitative researchers objectively collect data, yet maintain their independence from the process. The obtained dataset is subject to further statistical analysis in order to generate findings. Quantitative researchers recall the theoretical position introduced at the beginning of the study to verify or oppose its validity. The systematic and precisely structured approach of quantitative research underlies an accurate phenomenon measurement (Walter & Andersen, 2013). Objectivity and generalizability are the core priorities and strengths of quantitative research. However, quantitative research cannot capture the subtle nuances of the subjective worldview, which governs qualitative design (Creswell, 2014).

Further, the qualitative research methodology may be considered a display of poor interest in numbers and figures in order to investigate the phenomenon flexibly, which enables adjustment to different situations. Human interactions that facilitate an exchange of individual ideas, attitudes, beliefs, experiences, and perceptions are of primary value for qualitative research in studying social reality (Klenke, 2016). In the pursuit of access to individuals' minds and experiences, qualitative methodology requires the researcher to become an integral part of the studied reality in order to collect and analyze data independently. This integration enables qualitative researchers to adapt to the given situation and capture emerging behavioral nuances or internal motifs. Since data collection and analysis are inseparable from qualitative researchers, various techniques and methods are provided for data recording, transcribing, translating, synthesizing, and interpreting (Merriam & Tisdell, 2015). Using these techniques, qualitative researchers gain an in-depth understanding of the matter and can determine the social meaning attributed to reality by the studied group of individuals. The possibility of insight into reality is the key strength of qualitative research, which, nevertheless, reduces generalizability and application of findings to wider populations because of the small sample size and subjective interpretation.

However, both qualitative and quantitative research philosophies have advantages and disadvantages in studying world phenomena. The choice of a philosophic point of view depends on the research purpose and the objectives pursued by a study. The research aim of this study was to investigate the relationship among affinity groups, mentoring, training and development, and the perceived leadership advancement of minorities. The suggested associations required accurate testing and measuring of

numerical data using statistical analytical tools. Simultaneously, information was obtained from those in the top management who were employed in health care insurance organizations, which allowed the prediction of a limited sample of research participants and convenience sampling of the target population to recruit the maximum eligible individuals. Features of both positivism and constructivism were included in the study as well as quantitative and qualitative research. In other words, the study's data were obtained and analyzed in a deductive and objective manner while incorporating value in the produced findings (Schoja, 2016). Realism was the research philosophy for this quantitative research study. The next section includes a detailed overview of the selected research design and method.

## Research Method and Design Appropriateness

Aligned with the strengths and weaknesses of the qualitative and quantitative approaches and methodological strategies, this study was grounded in the realism philosophical perspective as an investigation of minority leadership in health care. The quantitative research methodology was utilized in order to help explain the impact of various interventions on the recognition of diversity in health care management to grant minority employees access to leadership positions. Therefore, a quantitative, correlative study design with multiple regression analysis was employed in this research. The focus of this study was on investigating the extent of the relationship between diversity management interventions and the leadership advancement of minorities. In line with the research hypotheses, diversity management interventions were regarded as the independent variable, while the perceived advancement of minorities into leadership positions is a dependent variable.

Quantitative research was appropriate for the study because the collected data were analyzed using statistical methods. Quantitative research involves collecting data in numerical forms, such as durations, scores, ratings, or scales. Data can be collected in naturalistic or controlled environments and may range from specialized populations or samples of general populations (Jupp, 2006). The main portion of the survey instrument for this study was a Likert-type scale that enabled responses to be converted to a numerical scale. The Likert-type scale has an advantage over other instruments, such as William Stephenson's Q-methodology, because of its ease of administering, ability to standardize data collection, familiarity in a widespread audience, and ability to compare scores of respondents to each other (Ho, 2017). In this study, minorities revealed how they perceive diversity management interventions may impact the leadership advancement of minorities.

According to Iversen (2004), "a quantitative research project is characterized by having a population for which the researcher wants to draw conclusions, but it is not possible to collect data on the entire population" (p. 897). Quantitative research also supports realist epistemology. Under this paradigm, facts about the world and behavior in the world are produced and measured, thereby contributing to human knowledge (Jupp, 2006). Because the exact number of minorities in leadership positions within the health care insurance is unknown, the current study assisted in the understanding of the perceptions of a small sample of available participants. This condition predefined before the actual research process is inconsistent with quantitative research methodology, which entails selection and recruitment of a large sample size through randomization to test the hypothesized cause-effect associations (Creswell, 2014).

According to the realism research philosophy, an investigator can follow either the quantitative or qualitative research methodology to convey value-laden research. Qualitative analysis is not appropriate for this study because qualitative research is an approach based on non-numerical forms of data, such as words and documents, which can be subjective (Christensen, Johnson, & Turner, 2011). Further, qualitative data are usually collected in the field or natural settings, such as in the office or in a board meeting. Observations in qualitative research are usually exploratory and open-ended, which produce data for interpretation rather than testing of hypotheses. Given the evidence cited above, quantitative methods for data collection and analysis was used to produce an objective examination and measurement of associations among affinity groups, mentoring, training and development, and the perceived leadership advancement of minorities. However, it is the philosophic underpinnings of realism that allow some deviations in research procedures, such as convenience sampling and small sample size typically observed in qualitative research (Merriam & Tisdell, 2015).

Surveying is the most widely used method of quantitative research because of its ability to collect a large volume of data within a single point of time or over a longer period. By obtaining a significant data set, the use of the survey is aimed at seeking to observe, test, and measure suggested causal relationships between different phenomena or patters of a phenomenon (Rea & Parker, 2012). In the pursuit of extensive data, surveying requires the selection and recruitment of a large-scale sample of respondents to achieve high representativeness of the target population. As such, surveying involves the development and distribution of a questionnaire—with close-ended statements that have a predefined answer—via email, phone, or by hand to ensure convenience and simplicity in

completing a survey form. Hence, through surveying, the researcher can collect a large data set in a cost- and time-efficient manner.

Moreover, the researcher can utilize the survey method to investigate variables with distinct response categories to address multiple values of the target population (Beam, 2012). The researcher can capture and describe characteristics and behavior patterns displayed in response to a particular phenomenon that is relevant for wider populations. Another advantage of survey research is with regard to a high level of anonymity and confidentiality granted to respondents through the impersonal collection of data. A survey was used for this study's data collection in order to obtain the ideas and perceptions of minorities in health care insurance organizations regarding the effectiveness of affinity groups, mentoring, and training and development diversity-management interventions in producing leadership advancement of minorities.

The hypotheses for the current study were formulated on the ground of empirical findings in the field of health care leadership and representation of minority populations in top-management positions. Indeed, Wallner (2008) suggested that training and development have a strong relationship with the advancement of African Americans, but affinity groups and mentoring were not a significant factor. This study expands upon Wallner's (2008) research to explore the relationship between the leadership advancement of minorities and affinity groups, mentoring, and training and development in health care insurance organizations. As such, the correlational study design was the most appropriate method to determine if there is a relationship between two or more variables (Lavrakas, 2008). In the context of the planned research, the correlation between the perception of the leadership advancement of minorities (dependent variable)

and the perception of diversity management interventions—affinity groups, mentoring, and training and development—(independent variable) were examined and measured.

Correlational studies are a traditional positivist method for studying leadership. As part of the positivist paradigm, individuals are positive about contributing to new knowledge when contributions are through a scientific method (McGregor & Murnane, 2010). Rarely can mathematical relationships in correlational studies fully explain "tacit personal beliefs and values that drive meaning-making" (Latham, 2014 p. 124). However, Latham (2014) suggested that correlational studies offer the best initial approach. This is because correlational research can help understand if the direction and strength of the relationship between variables are either positive or negative (Walker, 1989).

Further, regression analysis is a statistical method that examines the correlation between the predictor or independent variable and a criterion or dependent variable (Vogt, 2007). Regression analysis is not used to explain or fully predict the relationship between variables. Single regression analysis is done when there is only one independent variable versus a dependent variable, while multiple regression analysis consists of two or more independent variables. The independent variable in the multiple regression analysis in this study was the perception of diversity management interventions, identified as affinity groups, mentoring, and training and development. The dependent variable was the perception of the advancement of minorities in leadership positions of health care insurance organizations. Regression analysis was used in this study in order to understand if and to what extent there is a relationship between the perceptions of diversity management interventions and leadership advancement of minorities.

## Population and Sampling

The underlying purpose of this research project was to increase cultural acceptance and diversity in health care leadership by determining the efficiency of different diversity management interventions on the perceived leadership advancement of minorities. Seeking to investigate whether affinity groups, mentoring, and training and development contributed to improving minorities' access to leadership positions in the health care insurance industry, the study targeted minority leaders working in health care insurance organizations. Blacks or African Americans, Asians, and Hispanics were the target minority population for this study. By capturing the responses of minorities who succeeded to obtain a leadership position in the sector, the study's focus was on factors that facilitated their promotion, notably diversity management interventions. Minority leaders within the health care insurance industry—self-identified by titles such as managers, directors, vice presidents, presidents, and C-suite executives—were invited to participate in this research project. This study was limited to the health care insurance industry, which may provide explanations that are not represented in a broader national context.

Weller (2015) suggested that a meaningful size of population can be subjective. However, larger sampling sizes are necessary to detect smaller differences in studies. Population sizes are also meaningful for generalizing to larger populations. The number of minorities in leadership positions within the US was unknown. Using a confidence level of 95% and a margin of error of 5%, the sample size does not significantly change whether the total population size was 5,000 or 500,000. Theoretical calculations by Creative Research Systems (2012) and SurveyMonkey (2017) supported targeting a

sample size of 384 minority leaders. However, Wallner's (2008) study demonstrated that this is overly optimistic. As such, the population sample size for this study was determined using *a priori* G*Power 3.1 analysis (Faul, Erdfelder, Buchner, & Lang, 2009). For a one-tailed test, using a small effect size of .15, an alpha level of .05, and a power level of .95, a minimum sample size of 74 participants was required to achieve empirical validity. Figure 1 illustrates the variance in sample size that is driven by levels of margin of error.

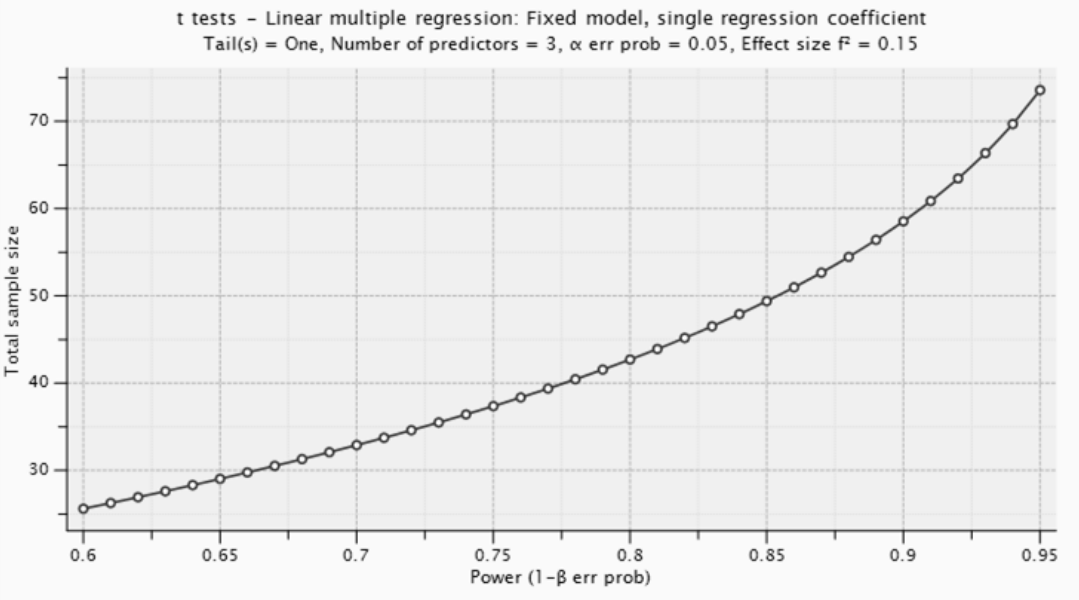


*Figure 1*. Plot of G*Power linear multiple regression sample size analysis.

Upon identifying health care insurance organizations that were eligible for participation, the study's focus was on conducting a precise evaluation of potential respondents to ensure their suitability for the current research and the representativeness of the target population. As such, a convenience sampling method was used to select the participants. Under this sampling method, participants "are selected conveniently, drawing on those that are most available" (Abbott & McKinney, 2013, p. 123). While

convenience sampling is not generalizable to the target population, results from the study may help organizations identify opportunities for addressing leadership advancement of minorities. Moreover, the results from the study also continue to support an open dialogue on the role of diversity management interventions. Participants were recruited through advertisements placed on a social media network website and application (Facebook), an online professional networking website and application (LinkedIn), and an online platform for research participants (FindParticipants.com). All respondents who volunteered to participate in the project were initially told about the research project, its purpose, and its significance. The voluntary participation was explained, and protective measures were taken to ensure participant's confidentiality as well as the privacy and security of the information shared. All participants were provided with a gift card for completing the survey.

**Informed Consent and Confidentiality**

For those who inquired to obtain additional information on the survey following the advertisements on Facebook, LinkedIn, and FindParticipants.com, an invitation (Appendix C) was sent to participate in the online survey. Within the invitation was a brief overview of the research purpose and method, explaining the study's focus on investigating the efficiency of various diversity management interventions in advancing minorities in their access to leadership positions in the industry. Participants were free to refuse to participate in the survey or to withdraw from the survey at any time. A link to the survey, which was accessible through SurveyMonkey, was included in the invitation. An informed consent form (Appendix C) was provided on the introductory page on SurveyMonkey. Before advancing to the survey, the participant acknowledged and

accepted the terms of the informed consent. The acceptance was signified as an individual's agreement to participate in the survey study as well as their understanding of the planned research procedures, non-paid nature of participation, and measures taken to protect confidentiality and privacy. The informed consent form was aligned with the ethical standards of academic research, which implied that data were used only for this study and will be destroyed after three years. After the completion of the survey, a message was sent to thank the participants (Appendix E) for the valuable information they provided, Information on how to obtain and use the gift card was included in the message. The participant was required to send an email with the information within 30 days of the end of the study collection period. The emails were printed in Adobe PDF file format, stored on a standalone encrypted computer, and immediately deleted from email surveys. In this respect, all research data and the Adobe PDF for gift cards are stored on a standalone encrypted computer within the home office of the researcher and will remain there for three years after the completion of the study.

## Survey Instrumentation

The pursued research aim of identifying correlations between the predefined dependent and independent variables required the utilization of a quantitative research method. Surveys are the most suitable method for obtaining the desired data and facilitating further regression analysis. The Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey questionnaire (Appendix A) was the instrument used in this study. Pauline Wallner (2008) developed the 5-point Likert-type ODMICA to examine the relationship between diversity management interventions and the leadership advancement of African Americans. Wallner's (2008) study was

conducting among 56 African American volunteers across multiple firms and industries within the US. This study was an expansion upon Wallner's (2008) research with a focus on the health care insurance industry and extension to other minority groups, beyond African Americans, to participate in the study.

The ODMICA survey comprises nine different scales that form exogenous and endogenous variables. External factors influence the exogenous variable (i.e., individual leadership readiness and organizational diversity capacity) while internal factors influence the endogenous variable. The exogenous variable, individual leadership readiness, comprises two scales: initiative and commitment. Four scales (i.e., values, organizational climate, hiring and promotional practices, and employee engagement) measure perceptions of organizational diversity capacity. The perception of leadership advancement is the endogenous variable, which is influenced by three diversity management intervention scales (affinity groups, mentoring, and training).

Wallner (2008) divided the survey into three sections. The Organizational Diversity Climate Inventory (ODCI) section assesses employee engagement, hiring and promotion practices, and the organization's culture and values. This first section of the survey collected nominal data and also consisted of write-in and multiple-choice questions designed to capture the primary demographics of the respondent—age, gender, race, and position level. The Individual Satisfaction and Commitment Inventory (ISCI) section is an assessment of the leader's perception of opportunities to advance and their readiness for advancement. The Diversity Management Intervention Climate Inventory (DMICI) section examines the perception of the effectiveness of affinity groups, mentoring, and training and development. The second and third sections of the survey

collected ordinal data through a Likert-type scale consisting of five possible responses: 1 = *strongly disagree*, 2 = *disagree*, 3 = *neutral*, 4 = *agree*, 5 = *strongly agree*.

Given the evidence cited above, ODMICA is a comprehensive research instrument that enables investigating the aspects of diversity management interventions, individual leadership readiness, and perceived organizational diversity capacity, which constitute the current research interest. This investigation tool has been tested and validated empirically on identifying the leadership advancement of African Americans in response to affinity groups, mentoring, and training and development experiences. Wallner (2008) demonstrated significant ($p < .01$) one-to-one correlation between the three types of independent variable and significant coefficient regression between training and the development variable in multiple regression analysis. Hence, ODMICA is a reliable and valid tool that was well-suited to the current research purpose. The tool was used to collect the required data from minorities employed within health care insurance organizations across the US. This study is also an extension of Wallner's (2008) work if unknown historical threats to the validity of the initial study may have impacted results.

## Data Collection

Before undertaking direct research, it was essential to obtain the permission of the institutional ethics committee to conduct a study engaging human participants. In this respect, a detailed research proposal was presented to the relevant authority for review and approval. Next, the study proceeded to population selection and sampling procedures to recruit the sample of minorities who occupied management and leadership positions in health care insurance organizations. The participants in the selected sample were

contacted initially via advertisement (Appendix B) or FindParticipants.com. An invitation letter was sent to those who requested further information to introduce the research and how to participate in the survey (see Appendix C).

The ODMICA survey questionnaire was provided on the digital platform through SurveyMonkey to facilitate the ease of data collection from participants in various geographic locations within the US. An online survey also eliminated administrative burden and costs associated with maintaining paper surveys. A dedicated site was created on SurveyMonkey to provide a background on the objectives of the survey. Before participating in the study, participants provided their informed consent. The informed consent was presented on the introductory page of SurveyMonkey. Individuals who did not acknowledge and accept the informed consent form were not permitted to participate in the survey. Participants completed the survey in 30–45 minutes. The data collection period for the study spanned over two months. Participants could complete the survey at any time during this period. Efforts were taken to remind participants to complete the survey on SurveyMonkey if they had not already done so.

## Data Analysis

Correlational analysis, multiple regression analysis, and reliability analysis were included in the data analysis for this study. Statistical Package for the Social Sciences® Version 25 (SPSS) for Windows was the statistical data analysis package used for analyzing the raw data collected from the survey and translating into informative decision-making information. According to Greasley (2008), SPSS is "the most widely used software for the statistical analysis of quantitative data" (p. 4). Use of SPSS to examine descriptive statistics was necessary for survey questions related to gender, race,

and position level. Researchers can investigate one variable at a time or the relationships between variables using descriptive or associational statistics, such as means and standard deviation (Vogt, 2007). SPSS is used to support multiple regression analysis by testing "the effects of multiple independent variables on the dependent variable" (Abbott & McKinney, 2013, p. 185). Omnibus findings also were reviewed to help understand whether there was a combined effect of all the three dimensions of the independent variable on the dependent variable.

Using SPSS software, numerical quantities were attributed to the data collected through the ODMICA survey. The classic scenario for quantitative data collection was calculating descriptive statistics and inferential statistics to investigate and measure correlations between the predefined dependent and independent. In this respect, the analytical process in this study commenced with producing descriptive statistics to summarize the overall scope of socio-demographic characteristics distributed in the recruited sample (Mendenhall, Beaver, & Beaver, 2012). The results of the initial SPSS analyses were the mean, median, and standard deviations for affinity groups, mentoring, and training and development experiences of minority professionals in health care insurance organizations. The results of descriptive statistics were presented in a comprehensive format of Windows tables and figures, thereby ensuring good data visibility. Inferential statistics were collected after frequency analyses to study and measure the dependence of the perceived leadership advancement of minorities on different diversity management interventions—affinity groups, mentoring, and training and development. Multiple regression analysis was used to understand the extent of the suggested cause-effect associations and to generate related conclusions.

Research data collected for the study were tested to determine if the data can be analyzed using multiple regression analysis. There are four primary assumptions of multiple regression which researchers must ensure are not violated. The first is that "regression assumes that variables have normal distributions" (Osbourne & Waters, 2002, p.1). Outliers can be identified in data plots and histograms and eliminated once identified. The second assumption is that the relationship between dependent and independent variables is linear (Osbourne & Waters, 2002). If the relationship is not linear, there can be an increased risk of Type I and Type II errors for independent variables. Further, an examination of the linear relationship can occur through residual plots. The third assumption is that "variables are measured without error (reliably)" (Osbourne & Waters, 2002, p. 2). Each variable is difficult to measure, and each contains errors, even though the level of error for each variable may be acceptable. As variables are added to a study, the overall reliability of the study diminishes. Therefore, it becomes important to correct for low reliability. Last, in multiple regression analyses, researchers assume homoscedasticity, which means that the errors are the same across all levels of the independent variable. A visual examination of a plot of the residuals (the errors) helped understand that if residuals are scattered evenly, they demonstrate homoscedasticity, or if residuals are not scattered evenly, they indicate heteroscedasticity (Osbourne & Waters, 2002). When the study did not meet these assumptions, alternate statistical tests, such as the ordinal logistic regression, were applied

**Validity**

According to Vogt (2007), validity is an indication of the appropriateness and accuracy of the design and measurement of the research questions being investigated as

well as of the derived conclusions. Sullivan (2009) identified statistical conclusion, construct, internal, and external validity as the four major types of validity in quantitative research. Statistical conclusion validity is the extent of the relationship between dependent and independent variables and indicate the correctness of the researcher's conclusion regarding the nature of that relationship. Construct validity is the extent to which quantitative study is reflected accurately as such. It relates to the correctness of variable choice to represent a hypothetical construct and whether the researched variables capture its essence. One of the major issues related to this type of validity is confounding; this phenomenon refers to attributing a causal relationship to different sets of variables by different researchers who adopt varied approaches (Heppner, Wampold, & Kivlighan, 2013). Thus, it is possible to speak about strong construct validity if the measured variables represent the hypothesized constructs to a large extent. Wallner (2008) developed and refined the ODMICA survey instrument to reduce potential statistical and construct threats, leaving internal and external threats to validity.

**Internal Validity**

Internal validity is the degree of change in one variable due to another variable in terms of cause and effect (Sullivan, 2009). In other words, assessment of internal validity implies concluding whether the statement about the existence of a causal relationship between variables can be made with certainty. Wallner (2008) noted several potential internal threats. The respondent's current environment and exposure to organizational diversity initiatives may have resulted in different responses than if they were not recently exposed to diversity initiatives. The respondent's future aspirations also could be built around a false sense of security with regard to the reliance of diversity initiatives

rather than current reality. In addition, the length and timing of the survey may have resulted in respondents choosing extreme values for multiple responses, such as consistently responding (1) strongly disagree or (5) strongly agree.

**External Validity**

External validity is the ability to generalize results to a larger population (Sullivan, 2009). Given that the ODMICA survey used in this study was developed and validated by Wallner (2008), there is little concern regarding the instrument's validity across all named dimensions. Face-to-face administration of the survey could result in a threat to the validity of the study if special attention is given to some respondents over others or if organizational leaders selected those respondents to complete the survey who they believed would provide more favorable responses. Therefore, the survey was collected anonymously online in order to mitigate potential threats to validity.

## Reliability

The reliability or consistency of measurement and design is important for the replication of a study (Vogt, 2007). Reliability is an essential component of any instrument's evaluation because it determines the extent to which scores on the instrument are free from errors of measurement. One of the ways of ensuring the reliability of a survey as a research instrument is to conduct testing and retesting, where similar results suggest high reliability (Dornyei, 2014). However, a variety of validation procedures have been undertaken by the instrument's designer, Wallner (2008), with all findings precisely documented and published in the author's dissertation, which is indicative of a fair degree of reliability sufficient to consider this study's findings as being valid (Wilson, 2013). Moreover, there is a problem with testing and retesting, since

it is difficult to determine the best length of an interval between two administrations of the questionnaire for adequate reliability verification.

Wallner (2008) validated the survey instrument in this research using the split-half reliability—the simplest method of internal consistency estimation. The split-half reliability method includes the measurement of consistency between questions by dividing the study's survey questions into two groups and correlating the individual response scores on both halves of the questions. Researchers utilize Cronbach's alpha, the result of the split-half reliability method, to measure items that are believed to be correlated (Vogt, 2007). Cronbach alpha is appropriate when the assumption is that "all items measure the same latent variable, on the same scale, with the same degree of precision, with all true scores being equal" (Thurber & Kishi, 2014, p. 250). Wallner (2008) divided the entire sample ($n$ = 80) into two random halves ($n$ = 40) each until the results attained a Cronbach's alpha reliability of 0.806. Wallner (2008) initially developed the survey instrument with 11 scales. Two of the scales (interpersonal skills and competency) were later eliminated because of inadequate internal consistency reliabilities.

## Summary

An overview of the research design and methodology of the study, including discussions on the research questions, hypotheses, population sample, survey instrumentation, data collection and analysis, and validity and reliability, was included in Chapter 3. A quantitative, correlational study with multiple regression analysis was appropriate for understanding the relationship between the perceptions of (a) affinity groups, (b) mentoring programs, and (c) training and development and the leadership

advancement of minorities. Data from the study were administered to minority leaders in the health care insurance industry and collected through an online Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey instrument with a 5-point Likert-type scale over a period of six months. Data obtained through the online survey were analyzed using SPSS for Windows. Chapter 4 includes the results and findings from the study's data analysis and testing of the hypotheses.

# Chapter 4

## Results

An overview of the research methodology used in this current quantitative study was provided in Chapter 3. A quantitative, correlational study was selected to determine the possible relationship between independent and dependent variables. The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health insurance organizations in the United States. The independent variable for the research study was diversity management interventions, namely affinity groups, mentoring programs, and training and development. The dependent variable was the leadership advancement of minorities. Four research questions formed the basis of the study:

1. Is there a relationship between the perception of minorities about diversity management interventions and leadership advancement of minorities in health care insurance organizations?
2. Which of the three types of diversity management interventions (affinity groups, mentoring, and training and development) have a greater relationship with the leadership advancement of minorities in health care organizations?
3. To what degree do minorities perceive promotional opportunities are available to them in health care insurance organizations?
4. To what degree do minorities perceive they have an understanding of how to advance in leadership in health care insurance organizations?

Minority leaders self-identified as managers, directors, senior directors, associate vice presidents, and above from health care insurance organizations within the United States were invited to participant in the study. The target population size was 74 minority leaders from health care insurance organizations within the United States. The sample size was 75 participants after two declined to participate resulting in a response rate of 97.4% (75 of 77 participants). Advertisements placed on FindParticipants.com, an organization experienced in the recruitment of research participants for academic research studies, and two online social media websites, Facebook and LinkedIn, facilitated the recruitment of participants for the study. The ability to limit recruitment to individuals working full time in the insurance industry was also provided in FindParticipants. Professionals interested in the study received an email indicating the purpose of the study and information on how to access the study.

Chapter 4 includes the results of quantitative analysis on the topic of leadership advancement of minorities in the health care insurance industry. The data in Chapter 4 are organized to provide a discussion on the instrumentation, the data collection process, participant demographics, and data analysis. Data analysis was used to determine the degree of the relationship between the dependent and independent variables. A summary of the results and analyses includes table illustrations and percentages.

## Instrumentation

The data collection instrumentation was the Organizational Diversity Management Interventions Climate Assessment (ODMICA). Figure 2 illustrates the grouping of questions from the ODMICA survey that form the scales used to evaluate the relationship between diversity management interventions and the perceptions of

leadership advancement. The dependent variable, the perceived leadership advancement, consisted of questions grouped to form two categories or seven scales: organizational diversity capacity (values, organizational climate, hiring and promotional practices, and employee engagement) and individual leadership readiness (interpersonal skills, competency, and commitment). Participants accessed the ODMICA survey online through Survey Monkey. The survey consisted of write-in, multiple-choice, and 5-point Likert-type scaled questions designed to capture primary demographics and diversity management intervention themes. Volunteer participants received an electronic $25 Target gift card upon completion of the survey.

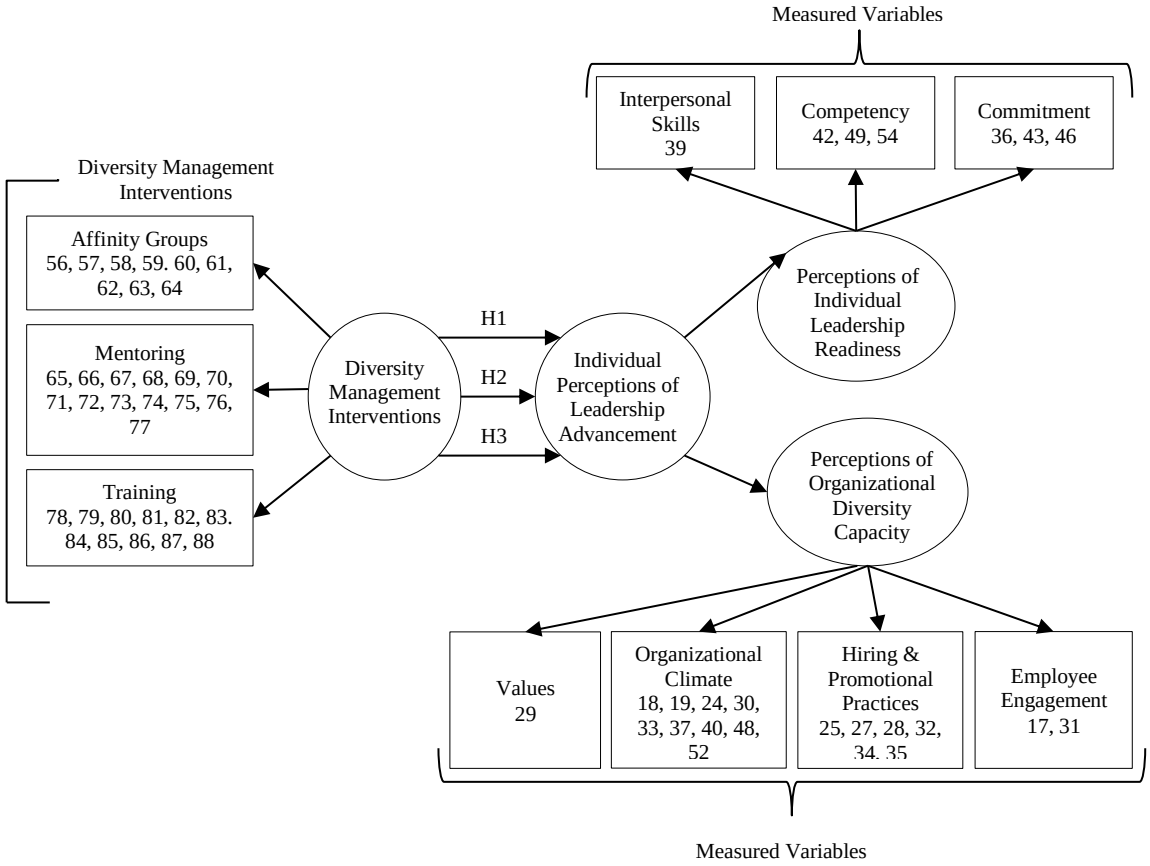


*Figure 2*. Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey model: Perceived leadership advancement.

## Data Collection Process

The raw data collected from participants consisted of survey responses by question and by scale. Study participants acknowledged their agreement to participate in the study on Survey Monkey's informed consent page, which was a requirement before advancing to the survey questions. The online survey administration suppressed the identity of the participants to ensure confidentiality and privacy. Study participants were assured that their information would be kept confidential and at no time would personal information be linked to their survey. The data file that contained the participants' responses was downloaded from Survey Monkey and transferred into the researcher's standalone computer. The data were analyzed using the Statistical Package for the Social Sciences® Version 25 (SPSS) for Windows software. Results from the study could be used by leaders within the health care insurance industry as information and a template for leadership development and advancement of minorities.

## Results and Discussion

The study involved running descriptive statistical analyses of the demographic data self-disclosed by the participants. Descriptive statistics allowed an understanding of the minority population within the health care insurance industry captured. Statistically significant correlations between the study's variables was further detected through multivariate multiple regression analysis. Data analysis was conducted using Pearson's and Spearman's rank correlations, which ensured correct interpretation to address the research questions.

**Descriptive Analysis of Demographics**

The first series of analyses consisted of descriptive statistics, providing the frequencies for the following sample demographics: age, gender, race, education, and occupation. The information in Tables 1-6 can be used to profile the study participants. On average, the typical participant of this study was male (80%). Based on the data findings, most participants were either Asian (40%) or Black (37.3%). The largest demographic age group of the participants was between the ages of 31 and 40 (44%). The majority (96%) of participants held a bachelor's degree or higher. Approximately half (50.7%) of the participants held a middle management position. The majority (77.3%) of the study participants also worked in their organizations for less than ten years.

Table 1

*Frequency distribution for the sample (N=75): Age*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| 25-30 | 17 | 22.7 |
| 31-40 | 33 | 44.0 |
| 41-50 | 20 | 26.7 |
| 51+ | 5 | 6.7 |
| Total | 75 | 100.0 |

Table 2

*Frequency distribution for the sample (N=75): Gender*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Male | 60 | 80.0 |
| Female | 15 | 20.0 |
| Total | 75 | 100.0 |

Table 3

*Frequency distribution for the sample (N=75): Race*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Asian | 30 | 40.0 |
| Black (from U.S. Caribbean, Africa, Other) | 28 | 37.3 |
| Hispanic | 14 | 18.7 |
| All other groups | 3 | 4.0 |
| Total | 75 | 100.0 |

Table 4

*Frequency distribution for the sample (N=75): Education*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| MBA/MS | 26 | 34.7 |
| BA/BS | 36 | 48.0 |
| DM/DBA/EdD | 2 | 2.7 |
| Ph.D. | 7 | 9.3 |
| Other post graduate work | 1 | 1.3 |
| Professional development | 2 | 2.7 |
| No formal college degree | 1 | 1.3 |
| Total | 75 | 100.0 |

Table 5

*Frequency distribution for the sample (N=75): Occupation*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Senior Exec | 1 | 1.3 |
| Senior Manager | 22 | 29.3 |
| Director | 12 | 16.0 |
| Middle Manager | 38 | 50.7 |
| Supervisor | 1 | 1.3 |
| Team Leader | 1 | 1.3 |
| Total | 75 | 100.0 |

Table 6

*Frequency distribution for the sample (N=75): Years of Employment at the Organization*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| 2 – 5 years | 30 | 40.0 |
| 6 – 9 years | 28 | 37.3 |
| 10 – 15 years | 14 | 18.7 |
| 16+ years | 3 | 4.0 |
| Total | 75 | 100.0 |

**Study Questions**

Four research questions were developed to guide the study. Three hypotheses were formed to investigate the first two questions:

1. Is there a relationship between the perception of minorities about diversity management interventions and leadership advancement of minorities in health care insurance organizations?
2. Which of the three types of diversity management interventions (affinity groups, mentoring, and training and development) have a greater relationship with the leadership advancement of minorities in health care organizations?

The study's third and fourth research questions were:

3. To what degree do minorities perceive promotional opportunities are available to them in health care insurance organizations?
4. To what degree do minorities perceive they have an understanding of how to advance in leadership in health care insurance organizations?

Table 7

*Pearson and Spearman's Rho Correlations for Diversity Management Interventions with Perceived Leadership Advancement (N = 75)*

| | Perceived Leadership Advancement | |
|---|---|---|
| Diversity Management Interventions | Pearson | Spearman's Rho |
| Affinity Groups | .072 | .309 |
| Mentoring Programs | .010 | .385* |
| Training and Development | .627** | .627** |

* = $p < .005$, ** = $p < .0005$

**Hypothesis One Results**

Null hypothesis one was $H1_0$: There is no significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations. The related alternative hypothesis was $H1_A$: There is a significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations. Both the Pearson correlation ($r(75) = .072$, $p = .482$) and the Spearman correlation ($r_s(75) = .309$, $p = .008$) were not significant, which was support to accept the null hypothesis at both the 95% and 99% levels of confidence. Based upon this statistic of the surveyed population, there is not a relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations for this surveyed population.

**Hypothesis Two Results**

Null hypothesis two was $H2_0$: There is no significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations. The related alternative hypothesis was $H2_A$: There is

a significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations. The Pearson correlation ($r(75) = .010$, $p = .925$) was not significant while the Spearman correlation ($r_s(75) = .385$, $p = .001$) was significant and positive. The findings were partial support for the alternative hypothesis at both the 95% and 99% levels of confidence. Based upon this statistic of the surveyed population, there is a relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations for this surveyed population.

**Hypothesis Three Results**

Null hypothesis three was $H3_0$: There is no significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations. The related alternative hypothesis was $H3_A$: There is a significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations. Both the Pearson correlation ($r(75) = .627$, $p < .0005$) and the Spearman correlation ($r_s(75) = .627$, $p < .0005$) were significant and positive at both the 95% and 99% levels of confidence, which was support to reject the null hypothesis. Based upon this statistic of the surveyed population, there is a relationship between the perception of minorities about training and development programs and the leadership advancement of minorities in health care insurance organizations for this surveyed population.

**Further Analysis of the Hypotheses**

Testing of the three hypotheses resolved the second research question by confirming that the perception of training and development had the strongest relationship to perceived leadership advancement compared to training and development or affinity groups. Additional statistical analysis was also applied to understand further if other interactions may influence results. As reported by ANOVA analysis, three intervening variables (i.e., race, title, and age) had significant *p-values* for the dependent variable, perceived leadership advancement, and two of the three independent variables, affinity groups and training and development.

1. Leadership Advancement *(n=75):*

A. Age: $F_{(3, 71)} = .077$, $p = .972$, not significant

B. Gender: $F_{(1, 73)} = .053$, $p = .819$, not significant

C. Education: $F_{(6, 68)} = 1.315$, $p = .263$, not significant

D. Race: $F_{(3, 71)} = 4.352$, $p = .007$, significant

E. Title: $F_{(5, 69)} = 4.499$, $p = .001$, significant

2. Affinity Groups *(n=75)*

A. Age: $F_{(3, 68)} = 4.650$, $p = .005$, significant

B. Gender: $F_{(1, 70)} = .702$, $p = .405$, not significant

C. Education: $F_{(6, 65)} = 1.315$, $p = .263$, not significant

E. Race: $F_{(3, 68)} = 1.944$, $p = .131$, not significant

E. Title: $F_{(4, 67)} = 2.892$, $p = .029$, not significant

3. Mentoring Programs (*n=75*):

A. Age: $F_{(3, 69)} = 1.343$, $p = .268$, not significant

B. Gender: $F_{(1, 71)} = .305$, $p = .582$, not significant

C. Education: $F_{(6, 66)} = 1.176$, $p = .330$, not significant

D. Race: $F_{(3, 69)} = 1.800$, $p = .155$, not significant

E. Title: $F_{(5, 67)} = 1.530$, $p = .192$, not significant

4. Training and Development ($n=75$):

A. Age: $F_{(3, 71)} = 1.029$, $p = .385$, not significant

B. Gender: $F_{(1, 73)} = .581$, $p = .448$, not significant

C. Education: $F_{(6, 68)} = 1.740$, $p = .125$, not significant

D. Race: $F_{(3, 71)} = 1.688$, $p = .177$, not significant

E. Title: $F_{(5, 69)} = 4.129$, p =.002, significant

**Correlations between the Variables**

Correlations between the independent variables, affinity groups, mentoring programs, and training and development, were significant at p<.005. However, when conducting a stepwise multiple regression analysis with perceived leadership advancement as the dependent variable, only training and development were identified with a significant regression coefficient (Table 13). Findings from affinity groups and mentoring programs could not be used to significantly explain variances in the dependent variable, perceived leadership advancement.

**Research Question Three**

Study data collected from the 75 respondents were analyzed to investigate the degree to which minorities perceived that there were promotional opportunities available to them in the health care insurance industry. When asked about the availability of in-house promotional opportunities, 66.7% of the participants rated this question as

*5=strongly agree* (14.7%) and *4=agree* (52.0%). Based upon this statistic of the surveyed population, there is a general agreement that minorities believe that there are promotion opportunities available to them, but without great certainty.

Table 8

*Frequency distribution for the sample (N=75): In-House Promotional Opportunities*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Disagree | 7 | 9.3 |
| Neutral | 18 | 24.0 |
| Agree | 39 | 52.0 |
| Strongly Agree | 11 | 14.7 |
| Total | 75 | 100.0 |

**Research Question Four**

The fourth research question was analyzed to investigate the degree to which minorities perceived they had an understanding of how to advance in leadership in health care insurance organizations. When asked about understanding how to get ahead in the organization, 81.3% of the participants rated this question as *5=strongly agree* (25.3%) and *4=agree* (56.0%). Additionally, 80.0% of participants believed they practiced leadership skills, rating the question as *5=strongly agree* (21.3%) and *4=agree* (58.7%). Based on this statistic, minorities think that they know how to advance within their organizations and think that they have opportunities to exercise their leadership skills.

Table 9

*Frequency distribution for the sample (N=75): Understanding the Organizational Landscape*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Disagree | 1 | 1.3 |
| Neutral | 13 | 17.3 |

Table 9 (Continued)

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Agree | 42 | 56.0 |
| Strongly Agree | 19 | 25.3 |
| Total | 75 | 100.0 |

Table 10

*Frequency distribution for the sample (N=75): Practicing Leadership Skills*

| Demographic Variable | Frequency | Percent |
|---|---|---|
| Disagree | 1 | 1.3 |
| Neutral | 13 | 17.3 |
| Agree | 42 | 56.0 |
| Strongly Agree | 19 | 25.3 |
| Total | 75 | 100.0 |

## Summary of Findings and Conclusion

The intent of the study was to gather data from a sample *(n=75)* of minority leaders working in health care insurance organizations in the United States. The convenience sampling method, drawing on those readily available, was employed to guide the selection of participants for the study (Abbott & McKinney, 2013). The survey was conducted through an online 5-point Likert-type scaled Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey instrument.

Correlational statistical methods were used to explore the extent of the relationship between the independent variables and the dependent variable. Two of the three independent variables, mentoring and training and development, had significant positive correlations with perceived leadership advancement, at the conventional p-value of ≤.05. Two intervening variables (i.e., race and title) were indicative of significant

positive associations with perceived leadership advancement. Affinity groups did not have a positive association with perceived leadership. A summary of the hypothesis findings appears in Table 11. Based upon findings from the study, minorities in leadership perceived that there were promotional opportunities available to them and that they know how to advance into leadership roles. Among the participants, blacks perceived opportunities existed at lower levels compared to other minority counterparts (Table 27). However, the data were inconclusive with regards to gender or age regarding perceived leadership advancement.

Table 11

*Summary of Findings*

| | Null Hypothesis | Findings |
|---|---|---|
| $H1_0$ | There is no significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations. | Accept |
| $H2_0$ | There is no significant relationship between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations. | Partially Accepted |
| $H3_0$ | There is no significant relationship between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations. | Reject |

The results and summary of the hypotheses using the sample (n=75) of minority leaders in the health care insurance organizations was included in Chapter 4. The findings of this quantitative, correlational study were the foundation for the discussion in Chapter 5. Chapter 5 contains the conclusions, interpretation of the results, implications, and suggestions for future research.

# Chapter 5

## Conclusions and Recommendations

Minorities are underrepresented in leadership positions in health care organizations. This underrepresentation is magnified by the disparity between the racial makeup of the leadership in health care and the demographics of the constituents that they serve. Among 6,338 U.S. registered hospitals minorities constituted only 14% representation on boards, 11% in executive leadership positions, and 19% in their first- and mid-level management positions (Health Research & Educational Trust, 2016). However, minorities comprise 32% of the patients that hospitals serve. In a 2015 survey conducted by healthcare executive search firm Witt/Kieffer (2015), only 24% of health care leaders who responded agreed that the diversity of management teams at healthcare organizations reflects their patient demographics. Health care organizations attempt to address these disparities and create diversity in leadership through different diversity management interventions and initiatives, such as targeted hiring and recruitment practices, mentoring, training, promoting diversity and implementing organizational policies (American Hospital Association, 2014; Health Research & Educational Trust, 2015; Henkel, 2016). Organizations have a vested interested in increasing diversity in leadership for many reasons, such as meeting regulatory requirements, avoiding lawsuits, improving productivity and financial performance, creating a diverse workforce and managing increasingly diverse work environments (Sania et al., 2015; Ordu, 2016).

Frankel (2015) suggested affinity groups, mentoring, and training and development programs as the three primary interventions that influence diversity in management. The purpose of this quantitative, correlational study was to examine

potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the United States. A total of 75 minority leaders from health care insurance organizations in the United States participated in the online study. Further understanding minorities' perceptions of the three diversity management interventions (i.e., affinity groups, mentoring programs, and training and development) that were the focus of this study may assist health care insurance organizations in finding a solution appropriate for their organization. Correlation of the variables was determined using Pearson and Spearman's Rho analyses. A secondary focus of the study was to understand the perceptions of minorities about the availability of leadership advancement opportunities and their ability to navigate in the organization. The four research questions investigated were:

1. Is there a relationship between the perception of minorities about diversity management interventions and leadership advancement of minorities in health care insurance organizations?
2. Which of the three types of diversity management interventions (affinity groups, mentoring, and training and development) have a greater relationship with the leadership advancement of minorities in health care organizations?
3. To what degree do minorities perceive promotional opportunities are available to them in health care insurance organizations?
4. To what degree do minorities perceive they have an understanding of how to advance in leadership in health care insurance organizations?

Chapter 5 includes a review of the research findings and interpretation of the results presented in Chapter 4. Major research conclusions and comparisons of the research to the literature review are discussed. The study's implications and recommendations for future research are also conferred. A summary is presented at the conclusion of Chapter 5.

## Findings and Interpretation

Based on the results (Table 7) from the study, there was a significant relationship between the perception of minorities about two of the three diversity management interventions and leadership advancement of minorities in health care insurance organizations. For the surveyed population, minorities believed there were available opportunities to advance in health care insurance organizations (Table 8) and perceived they understood how to advance in leadership (Table 9). However, only 37.4% of the study participants perceived the board of their organizations to be racially diverse, and only 45.3% perceived their senior leadership to be racially diverse. The conclusion is that the individual perceptions of the minority leaders in the study may not be fully aligned with their organizations' overarching efforts to increase diversity in leadership. Mentoring and training and development may be interventions that their health care insurance organizations may want to consider additional investments with the goal of increasing diversity in leadership.

### Affinity Groups

As reported in the results (Table 7) from the study, there was not a significant relationship between the perception of minorities about affinity groups and the leadership advancement of minorities in health care insurance organizations. Frequency distributions

of the study data collected from the sample of 75 minority leaders in health care insurance organizations were analyzed. Based upon the data, 72% of participants had formal affinity groups, and 66.7% had informal affinity groups available within their organizations. When asked if a member of an affinity group, 53.3% of participants indicated membership. Additionally, only 56% perceived that affinity group members assisted in leadership advancement. Participants perceived a low level of individual leadership readiness and a moderate level of organizational diversity capacity associated with affinity groups (Table 12).

Table 12

*Interpretation of the results*

| | Dependent Variable: Leadership Advancement | |
|---|---|---|
| Independent Variables | Individual Leadership Readiness | Organizational Diversity Capacity |
| Affinity Groups | Low Readiness | Moderate Readiness |
| Mentoring Programs | Moderate Readiness | Moderate Readiness |
| Training and Development | High Readiness | High Readiness |

The conclusion is that while affinity groups may offer support for minorities, membership in affinity groups themselves are not an indication of likelihood to advance in leadership. Many advantages to affinity groups, ranging from reducing mistrust and social tensions in organizations to creating feelings 1of respect and building strategic relationships were identified from the literature review (DiversityInc., 2012b; Feldman et al., 2011; Goode & Dixon, 2016; Randy, 2014). These advantages may help explain why minorities continue to participate in affinity groups and why organizations continue to support them. However, Lambertz-Berndt (2016) suggested that affinity groups fail to

empower may explain why there is not a significant relationship between affinity groups and leadership advancement.

**Mentoring Programs**

A significant relationship did exist between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations at $p<.005$ (Table 7). Frequency distributions of the study data collected from the sample of 75 minority leaders in health care insurance organizations were analyzed. Based upon the data, 76% of participants had formal mentoring programs, and 52% had informal mentoring programs available within their organizations. The majority (78.7%) of participants perceived that mentoring programs assist in leadership advancement and 80% perceived that mentoring could help them get ahead. Although 72% of the participants indicated that they benefited from mentoring programs, only 37.3% indicated that they seek mentors from their same racial backgrounds. Participants perceived moderate levels of individual leadership readiness and organizational diversity capacity associated with mentoring programs (Table 12). Therefore, mentoring programs can be effective in aiding in leadership advancement. These findings are consistent with the literature review. Several studies (Clutterbuck et al., 2012; Kameny et al., 2013; Sharma & Freeman, 2014; Witt/Kieffer, 2015) identified mentoring as a best practice for creating diverse leaders and a source of empowerment and optimizing leadership potential. However, cross-racial mentoring may be necessary for minorities seeking leadership advancement, which may be because there is a lack of minorities in leadership positions in the health care insurance industry.

**Training and Development**

A significant relationship did exist between the perception of minorities about training and development and the leadership advancement of minorities in health care insurance organizations at $p<.0005$ (Table 7). Frequency distributions of the study data collected from the sample of 75 minority leaders in health care insurance organizations were analyzed. Based upon the data, 89.4% of participants had formal training and development programs available within their organizations. Participants perceived high levels of individual leadership readiness and organizational diversity capacity associated with training and development (Table 12). Many (69.3%) of the study participants perceived that participating in training and development programs would increase their likelihood to get promoted.

Therefore, the conclusion is that training and development programs can be effective for minorities seeking leadership advancement and as a tool for health care insurance organizations seeking ways to increase in leadership. The results are consistent with Wallner's (2008) findings and are further support of health care insurance organizations doing more to promote training and development programs. According to the literature review, training and development programs optimize employee's talents and allow organizations to promote from within the same organization, which may offer insight into why there is a significant relationship between training and development and leadership advancement (Alhejji et al., 2016; Gündemir et al., 2017; Thompson & Temple, 2015). Additionally, 79.3% of the participants indicated that they were proactive in seeking training and development opportunities. Based on this finding, there is a good level of willingness by minorities themselves to participate in diversity initiatives that

may lead to leadership advancement. However, when asked about the levels of diversity training within their organizations, only 54.7% perceived their organization to offer diversity awareness training programs and only 49.3% indicated that diversity awareness training was mandatory for all employees.

**Promotional Opportunities**

The research question "To what degree do minorities perceive promotional opportunities are available to them in health care insurance organizations?" was investigated in this research study. Only 9.3% of the study participants did not perceive there were in-house promotion opportunities. Further, 65.3% perceived executive leadership positions were open to everyone. This statistic perhaps could relate to the economic conditions at the time of the study. At the time of the survey, economists considered the job market as competitive, 164,000 new jobs were added to the U.S. economy, and the overall unemployment rate was at a low of 3.9% (Kitroeff, 2018). The unemployment rate for Blacks was also at the lowest levels on record at 6.6% but was still higher than 3.6% for Whites (Kitroeff, 2018). However, few study participants perceived their organizations recruit specific minority groups for team-leader roles, citing only 36% perceived their organizations to recruit for African Americans, 38.6% for Hispanic Americans, and 54.7% for Asian Americans. The conclusion from these statistics mentioned above is that while minorities see opportunities for promotion including executive leadership positions in health care organizations, minorities do not perceive organizations are making pro-active recruitment efforts to hire minorities into those leadership positions.

### Understanding the Organizational Landscape

The fourth research question was "To what degree do minorities perceive they have an understanding of how to advance in leadership in health care insurance organizations?". Only 1.7% of the study participants did not perceive to know how to get ahead in their organization. Furthermore, only 6.6% of participants indicated that they did not practice leadership skills in their job function. Based on this finding, minorities believe that they know how to use skills, such as power and influence, which are requirements to be successful as a leader.

## Implications of the Study

The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health care insurance organizations in the United States. Situational leadership theorists suggest that leadership approaches must change to adapt to the employees' needs (Dugan, 2017). By assessing employees' perceptions of organizational diversity capacity and individual leadership readiness, leaders can understand and identify organizational detractors to minority leadership advancement and determine specific diversity management interventions appropriate for the organization. Ongoing surveys of organizational diversity capacity and individual leadership readiness can also allow organizational practitioners to make changes to these interventions.

### Leadership Advancement: Organizational Diversity Capacity

Meaningful data about the participants' perceptions of the willingness of organizations in the health care insurance industry to accept a diverse leadership was

collected in the organizational diversity capacity inventory (ODCI) section of the survey. Studies (Brown, 2017; Jayanthi, 2016; Modern Healthcare, 2016) in the literature review were support that minorities are underrepresented in executive leadership positions. Findings from the present study were consistent with the literature review. Only 37.4% of the study participants perceived the board of their organizations to be racially diverse, and only 45.3% perceived their senior leadership to be racially diverse. While minorities remain underrepresented, 66.7% of the participants perceived there to be in-house promotion opportunities available to them. The majority or 65.3% of the participants also perceived executive leadership promotions were open to all employees. However, the ability for organizations to attract African Americans to entry-level positions was perceived to be low with only 37.3% of participants indicating as such. Additionally, only 36.0% perceived their organizations promoted African American employees to team-leader roles.

**Leadership Advancement: Individual Leadership Readiness**

Perceived individual leadership readiness was obtained through the individual satisfaction and commitment inventory (ISCI) section of the survey. The participants had high ratings for their leadership skills and how to advance in their organizations. Of the 75 participants, 81.3% indicated that they know how to get ahead in their organizations. The majority or 74.7% of the participants perceived that they possessed the skills needed for promotion and 80.0% perceived that they practiced leadership skills within their job functions. The participants also perceived that their supervisors had positive perceptions of them; 68.0% of the participants indicated that they received explicit instructions from

supervisor to complete tasks and 69.3% indicated that they received positive feedback from supervisor.

## Recommendations

Changing organizational perceptions is critical to the success of minorities in leadership positions. When Caucasians are perceived to be more suitable for leadership positions, the executive level will likely continue to be underrepresented for minorities (Festekjian et al., 2013). Change must be addressed from a variety of directions to occur and to be sustained (Dutta & Kleiner, 2015). Increasing leadership advancement of minorities occurs through a change in the organizational climate and the behaviors of leaders and organization members, including minorities themselves (Pleasant, 2017; Witt/Kieffer, 2015).

Organizational leaders must create change by endorsing efforts to remove societal, governmental, and structural barriers. Society and workplace structures that minorities work in can prevent them from achieving success (Johns, 2013). According to the study data, minorities recognized when there were opportunities to advance in leadership. The study participants also believed that they understood the requirements that it takes to advance. As part of this finding, perhaps other barriers are preventing them from advancing. The willingness to display their leadership skills supports the conclusion that they are not limiting themselves.

In accordance with the findings from the study, training and development programs may have the greatest impact among the different interventions followed by mentoring. Affinity groups may not have the same progress in leadership advancement. However, increased awareness achieved through affinity groups helps overcome barriers

to change and allows minorities to build relationships. While affinity groups, mentoring, and training and development programs individually may not change behaviors in a short period of time, these efforts help continue to put the dialogue of racial diversity in the forefront.

Minorities do have a role in leadership advancement as well. Minority leaders have an opportunity to use their experience of marginalization and discrimination to inform other leaders and to help promote effective decision making in organizational efforts against discrimination and in support of leadership advancement of minorities (Chin, 2013). Minorities seeking advancement must also be proactive in engaging in diversity initiatives to determine their success and continued support. This means actively seeking mentors and engaging in training and development programs when offered.

## Suggestions for Future Research

Promotional opportunities may be more reflective of the economic sentiment. During the time of the present study, the economy was considered relatively strong, and the unemployment rate was low. Minorities may perceive their experiences and opportunities for leadership advancement to be different during periods of economic downturns, recessions, or depressions. Additionally, the reality may be that their experiences are not the same during these times.

Future studies that focus one specific minority group may allow researchers to understand the specific types of diversity management initiatives that are more effective for a particular minority group in aiding in leadership advancement. This, however, may be a longer-term goal for organizations where overall general advancement of minorities

has been accomplished, but specific minority populations are still not representative of the clients they serve or the overall organizational makeup.

Researchers and organizational practitioners may find that using the ODMICA instrument for a more focused case study may yield unique findings. Within the health care insurance industry, geographic differences may yield exposure to different organizational ethnic compositions than those identified in this study. Further, establishing a dialogue with organizational leaders after sharing the results of the surveys may also yield greater and more immediate action for change.

## Summary and Conclusion

The purpose of this quantitative, correlational study was to examine potential relationships between minorities' perceptions of three diversity management interventions and the leadership advancement of minorities in health insurance organizations in the United States. Based upon results from the study, a significant relationship existed between the perception of minorities about mentoring and the leadership advancement of minorities in health care insurance organizations at $p<.005$. A significant relationship also existed between training and development and leadership advancement, but to a lesser degree. A significant relationship did not exist between the perceptions of affinity groups and leadership advancement. The study data also supported that minorities remain underrepresented in holding senior leadership positions in health care insurance organizations.

Health care insurance organizations that fail to endorse and invest in diversity and leadership development activities may encounter issues with diversity in management, employee dissatisfaction, employee turnover, and profitability (Health Research &

Educational Trust, 2016; Kim et al., 2012; Richard, 2000). Health care executives believe that minorities should have more opportunities to advance (Silver, 2017). Benefits of diverse leadership include greater employee commitment and empowerment as well as improvement in the quality of health care services.

Organizational practitioners seeking to increase diversity in leadership roles must take a proactive approach to seek change. Transformational leadership whose vision is receptive to diversity can influence organizational citizenship behaviors (OCBs), which includes the commitment, tenure, and productivity of employees (Gotsis & Grimani, 2016). Continuous open dialogue on the topic of diversity management interventions and other types of diversity and inclusion programs will further promote the moral and ethical obligations of organizations. Many benefits can include connectedness within organization subgroups, greater innovation, and addressing global concerns (Gotsis & Grimani, 2016). Organizations can take proactive measures such as using the Organizational Diversity Management Interventions Climate Assessment (ODMICA) survey to first assess the diversity climate and perceptions within the organization and to derive at long-term solutions for diversity and inclusion. Further use of the ODMICA tool can also determine if there are additional advantages to the three diversity interventions within specific organizations or with specific population subsets.

References

Abbott, M. L., & McKinney, J. (2013). *Understanding and applying research design.* Hoboken, NJ: John Wiley & Sons.

Aetna. (2016). *Workplace diversity*. Retrieved from https://www.aetna.com/about-us/diversity-inclusion/workplace-diversity.html

Ahmet, A. (2015). The role of leadership and organizational citizenship behaviour in efficient management. *African Journal of Business Management, 9*(20), 727-734. doi:10.5897/AJBM2015.7881

Algahtani, A. (2013). Diversity in the corporate setting. *International Journal of Business and Social Science, 4*(14), 51-57.

Alhejji, H., Garavan, T., Carbery, R., O'Brien, F., & McGuire, D. (2016). Diversity training program outcomes: A systematic review. *Human Resource Development Quarterly, 27*(1), 95-149. doi:10.1002/hrdq.21221

Allen, T. D., & Eby, L. T. (2011). *The Blackwell handbook of mentoring: A multiple perspectives approach*. Hoboken, NJ: John Wiley & Sons.

Allison, M. T. (1999). Organizational barriers to diversity in the workplace. *Journal of Leisure Research, 31*(1), 78-101. doi:10.1080/00222216.1999.11949852

Almaki, S. H., Silong, A. D., Idris, K., & Wahat, N. A. (2016). Challenges faced by Muslim women leaders in higher education. *Journal of Educational and Social Research, 6*(3), 75-86. doi:10.5901/jesr.2016.v6n3p75

American Hospital Association. (2014). Best practices for building leadership diversity programs. *Equity of Care*. Retrieved from

http://www.equityofcare.org/resources/resources/Best%20Practices%20for%20Building%20Leadership%20Diversity%20Programs.pdf

Anonymous. (2016). Diversity as a contributor to leadership effectiveness: Leadership styles to optimize employee skills and group outcomes. *Strategic Direction, 32* (7), 26-28. doi:10.1108/SD-04-2016-0053

Aries, N. R. (2004). Managing diversity: The differing perceptions of managers, line workers and patients. *Health Care Management Review, 29*(3), 172–180. doi:10.1097/00004010-200407000-00002

Armstrong, A., & Ashraf, S. (2011). Leadership competencies in a diverse culture. In K. Agard (Ed.), *Leadership in nonprofit organizations: A reference handbook.* (pp. 267-274). Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781412979320.n31

Babinski, P. J. (2016). The perceived importance of role-specific competencies for health care leaders establishes the need to expand role theory. T*he Health Care Manager, 35*(2), 164-179. doi:10.1097/HCM.0000000000000110

Bachman, R., & Schutt, R. K. (2014). *Fundamentals of research in criminology and criminal justice.* Thousand Oaks, CA: SAGE.

Baker, G. R. (2011). The roles of leaders in high-performing health care systems. *The King's Fund*. Retrieved from https://www.kingsfund.org.uk/sites/files/kf/Roles-of-leaders-high-performing-health-care-systems-G-Ross-Baker-Kings-Fund-May-2011.pdf

Barta, T., Kleiner, M., & Neumann, T. (2012). Is there a payoff from top-team diversity? *McKinsey Quarterly, 2,* 13-15.

Battle, B., Daniels, E., Hesselmann, J., & Thew, J. (2018). The role diversity and inclusion plays in achieving strategic goals. *HealthLeaders Magazine*, *21*(4), 32–36.

Beam, G. (2012). *The problem with survey research*. New Brunswick, NJ: Transaction Publishers.

Begeç, S. (2013). Effective diversity management initiatives. *International Review of Management and Marketing, 3*(2), 63-74.

Belias, D., & Koustelios, A. (2014). The impact of leadership and change management strategy on organizational culture. *European Scientific Journal, 10*(7), 451-470.

Berman, J. (2015, January 29). Soon, not even 1 percent of fortune 500 companies will have black CEOs. *The Huffington Post*. http://www.huffingtonpost.com

Berrey, E. (2014). Breaking glass ceilings, ignoring dirty floors: The culture and class bias of diversity management. *American Behavioral Scientist, 58*(2), 347–370. https://doi.org/10.1177/0002764213503333

Bertone, S., & Leahy, M. (2001). Chapter 11: Globalization and diversity management. In *Globalization, Employment & the Workplace* (pp. 207–238). Taylor & Francis Ltd / Books.

Black, T. R. (2002). *Understanding social science research*. (2nd ed.). London, England: SAGE Publications, Ltd. doi:10.4135/9780857020208

Brimhall, K. C., Lizano, E. L., & Barak, M. E. M. (2014). The mediating role of inclusion: A longitudinal study of the effects of leader–member exchange and diversity climate on job satisfaction and intention to leave among child welfare

workers. *Children and Youth Services Review, 40*, 79–88. http://dx.doi.org.ezproxy.uwe.ac.uk/10.1016/j.childyouth.2014.03.003

Brown, C. M. (2017, January 11). This is the end of black female CEOs in corporate America. *Black Enterprise*. Retrieved from http://www.blackenterprise.com/news/end-black-female-ceos-corporate-america/

Burns, C., Barton, K., & Kerby, S. (2012). The state of diversity in today's workforce. *Center for American Progress*. Retrieved from https://www.americanprogress.org/issues/economy/reports/2012/07/12/11938/the-state-of-diversity-in-todays-workforce/

Carter, P. W. (2018). Thought leadership: Championing diversity and inclusion a conversation with Connie Lewis Lensing, Senior VP of Litigation Department at Federal Express. *Defense Counsel Journal, 85*(1), 1–5.

Castellucci, M. (2017). Chief diversity officers lead charge for more-inclusive workforces. *Modern Healthcare, 47*(39), 0016.

Chaunda, S. L. (2012). *Handbook of research on workforce diversity in a global society: Technologies and concepts*. Hershey, PA: IGI Global.

Chaurasia, S., & Shukla, A. (2012). Diversity and its effect on firm performance: A critical review. *Journal of Strategic Human Resource Management, 1*(1), 14-22.

Chin, J. L. (2010). Introduction to the special issue on diversity and leadership. *The American Psychologist, 65*(3), 150.

Chin, J. L. (2013). Diversity leadership: Influence of ethnicity, gender, and minority status. *Open Journal of Leadership, 2*(1), 1-10. http://dx.doi.org/10.4236/ojl.2013.21001

Christensen, L. B., Johnson, R. B., & Turner, L. A. (2011). *Research methods, design, and analysis.* (11th ed.). Boston, MA: Allyn and Bacon.

Clawson, J. (2006). *Level three leadership: Getting below the surface* (3rd ed.). Upper Saddle River, NJ: Pearson Education.

Clutterbuck, D., Poulsen, K. M., & Kochan, F. (2012). *Developing successful diversity mentoring programs: An international casebook*. London: McGraw-Hill Education.

Cohn, D. (2016). It's official: Minority babies are the majority among the nation's infants, but only just. *Pew Research Center*. Retrieved from http://www.pewresearch.org/fact-tank/2016/06/23/its-official-minority-babies-are-the-majority-among-the-nations-infants-but-only-just/

Cohn, D., & Caumont, A. (2016). 10 demographic trends that are shaping the U.S. and the world. *Pew Research Center*. Retrieved from http://www.pewresearch.org/fact-tank/2016/03/31/10-demographic-trends-that-are-shaping-the-u-s-and-the-world/

Coleman, M. (2012). Leadership and diversity. *Educational Management Administration & Leadership, 40,* 592-609. doi:10.1177/1741143212451174

Colby, S. L., & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population: 2014 to 2060. Retrieved from http://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

Combs, G. M. (2002). Meeting the leadership challenge of a diverse and pluralistic workplace: Implications of self-efficacy for diversity training. *Journal of Leadership & Organizational Studies*, *8*(4), 1-16.

Conboy, K., & Kelly, C. (2016). *What evidence is there that mentoring works to retain and promote employees, especially diverse employees, within a single company?* Retrieved from http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1120&context=student

Cook, A., & Glass, C. M. (2014a). Above the glass ceiling: When are women and racial/ethnic minorities promoted to CEO?. *Strategic Management Journal*, *35*(7), 1080-1089. doi:10.1002/smj.2161

Cook, A., & Glass, C. M. (2014b). Analyzing promotions of racial/ethnic minority CEOs. *Journal of Managerial Psychology*, *29*(4), 440-454. doi:10.1108/JMP-02-2012-0066

Cook, A., & Glass, C. M. (2014c). The power of one or power in numbers? Analyzing the effect of minority leaders on diversity policy and practice. *Work and Occupations*, *42*(2), 183-215. doi:10.1177/0730888414557292

Creative Research Systems. (2012). Sample size calculator. Retrieved from http://www.surveysystem.com/sscalc.htm

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. Thousand Oaks, CA: SAGE Publications.

Cunningham, G. B. (2009). The moderating effect of diversity strategy on the relationship between racial diversity and organizational performance. *Journal of*

*Applied Social Psychology, 39*(6), 1445-1460. doi:10.1111/j.1559-1816.2009.00490.x

Curtis, E. F., & Dreachslin, J. L. (2008). Diversity management interventions and organizational performance: A synthesis of current literature. *Human Resource Development Review, 7*(1), 107-134. doi:10.1177/1534484307311700

Daly, J., Jackson, D., Mannix, J., Davidson, P. M., & Hutchinson, M. (2014). The importance of clinical leadership in the hospital setting. *Dove Press, 2014*(6), 75-83.

Darwin, J. R., & Palanisamy, C. S. (2015). The effects of work force diversity on employee performance in Singapore organizations. *International Journal of Business Administration, 6*(2), 17-29.

Dauvrin, M., & Lorant, V. (2015). Leadership and cultural competence of healthcare professionals: A social network analysis. *Nursing Research, 64*(3), 200-210.

Davis, D. R., & Maldonado, C. (2015). Shattering the glass ceiling: The leadership development of African American women in higher education. *Advancing Women in Leadership, 35*, 48-64.

Davis, P. D., Frolova, Y., & Callahan, W. (2016). Workplace diversity management in Australia: What do managers think and what are organizations doing? *Equality, Diversity and Inclusion: An International Journal, 35*(2), 81-98. doi:10.1108/EDI-03-2015-0020

De Dios, M. A., Kuo, C., Hernandez, L., Clark, U. S., Wenze, S. J., Boisseau, C. L., … Zlotnick, C. (2013). The development of a diversity mentoring program for

faculty and trainees: A program at the Brown Clinical Psychology Training Consortium. *Behav Ther (N Y N Y), 36*(5), 121–126.

DiversityInc. (2012a, August 16). *Hospitals, insurance companies, pharmas: Who benefits from the Affordable Care Act?* Retrieved from http://www.diversityinc.com/diversity-management/hospitals-insurance-companies-pharmas-who-benefits-from-the-affordable-health-care-act/

DiversityInc. (2012b, August 5). *The business benefits of resource groups.* Retrieved from http://www.diversityinc.com/resource-groups-2/the-business-benefits-of-employee-resource-groups/

Dobbin, F., & Kalev, A. (2016). Why diversity programs fail. *Harvard Business Review*. Retrieved from https://hbr.org/2016/07/why-diversity-programs-fail

Dolan, T. C. (2013). Increasing diversity in governance and management. *Journal of Healthcare Management, 58*(2), 84-86.

Dornyei, Z. (2014). *Questionnaires in second language research: construction, administration, and processing*. New York, NY: Routledge.

Dotson, E., & Nuru-Jeter, A. (2012). Setting the stage for a business case for leadership diversity in healthcare: History, research, and leverage. *Journal of Healthcare Management, 57*(1), 35-44. Retrieved from http://www.ache.org

Dreachslin, J. L. (2007). The role of leadership in creating a diversity-sensitive organization. *Journal of Healthcare Management, 52*(3), 151-5.

Dugan, J. P. (2017). *Leadership theory: Cultivating critical perspectives*. Hoboken, NJ: John Wiley & Sons.

Dumbravă, G. (2016). Cultural consequences of globalization. Major contemporary theories on the global-local interference. *Annals of the University of Petrosani Economics*, 16(1), 95–102.

Durand, M. A., & Chantler, T. (2014). *Principles of social research.* London, UK: McGraw-Hill Education.

Dutta, S. K., & Kleiner, B. (2015). The benefits of effective change management on an organization's culture. *Leadership & Organizational Management Journal*, *2015*(1), 120–128.

Eagly, A. H., & Chin, J. L. (2010). Diversity and leadership in a changing world. *American Psychologist, 65*(3), 216-224. doi: 10.1037/a0018957

Ehrke, F., Berthold, A., & Steffens, M. C. (2014). How diversity training can change attitudes: Increasing perceived complexity of superordinate groups to improve intergroup relation. *Journal of experimental social psychology, 53*, 193-206. doi:10.1016/j.jesp.2014.03.013

Ellis, P., & Abbott, J. (2013). Leadership and management skills in health care. *The British Journal of Cardiac Nursing, 5*(4), 200-207. http://dx.doi.org/10.12968/bjca.2010.5.4.47424

"Employee affinity groups". (2006). Employee affinity groups: Definition, purpose, legal issues. *Fair Employment Practices Guidelines*, (610), 1-3.

Equity of Care. (2016). Equity of care. Retrieved from http://www.equityofcare.org/

Eustace, A., & Martins, N. (2014). The role of leadership in shaping organizational climate: An example from the FMCG industry. *SA Journal of Industrial*

*Psychology/SA Tydskrif vir Bedryfsielkunde, 40*(1), Art. #1112. http://dx.doi.org/10.4102/sajip.v40i1.1112

Evans, J. S. T. B. (2013). *The psychology of deductive reasoning (Psychology revivals*). New York, NY: Psychology Press.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160.

Feldman, H. R., Greenberg, M. J., Jaffe-Ruiz, M., McClure, M. L., McBride, A. B., Smith, T. D., & Alexander, G. R. (2011). *Nursing leadership: A concise encyclopedia* (2d ed). New York: Springer Publishing Company.

Festekjian, A., Tram, S., Murray, C. B., Sy, T., & Huynh, H. P. (2013). I see me the way you see me. The influence of race on interpersonal and intrapersonal leadership perceptions. *Journal of Leadership & Organizational Studies, 21*(1), 102-119. doi:10.1177/1548051813486522

Florida Center for Nursing. (2014). *Addressing barriers in leadership for nursing*. Retrieved from https://campaignforaction.org/wp-content/uploads/2016/04/Addressing-Barriers-in-Leadership-for-Nurses-FL.pdf

Fox, D., Gouthro, M. B., Morakabati, Y., & Brackstone, J. (2014). *Doing events research: From theory to practice*. New York, NY: Routledge.

Frankel, B. (2015). Why top 50 companies beat Fortune 500 in diversity recruiting, promotions. *DiversityInc*. Retrieved from http://www.diversityinc.com/news/why-top-50-companies-beat-fortune-500-in-diversity-recruiting-promotions/

Freifeld, L. (2017). Discrimination at Work. *Training, 54*(3), 6. Retrieved from https://trainingmag.com/trgmag-article/discrimination-work

Frey, W. H. (2018). *The millennial generation: A demographic bridge to America's diverse future.* Washington, D.C.: Brookings Institution Press. Retrieved from https://www.brookings.edu/research/millennials/

Friedman, R. A., & Holtom, B. (2002). The effects of network groups on minority employee turnover intentions. *Human Resource Management, 41*(4), 405-421. Retrieved from http://search.proquest.com/docview/222069612?accountid=45

Futrell, G. D., & Clemons, T. N. (2017). Top ranked hospitals: Does diversity inclusion matter? *International Journal of Pharmaceutical and Healthcare Marketing, 11*(1), 49-59. doi:http://dx.doi.org.contentproxy.phoenix.edu/10.1108/IJPHM-12-2015-0060

Gabriel, M. (2015). *Fields of sense: A new realist ontology*. Edinburgh, UK: Edinburgh University Press.

Garr, S. (2014). New research reveals diversity & inclusion efforts well-intentioned, but lacking. Retrieved from http://www.bersin.com/Blog/post/New-research-reveals-Diversity--Inclusion-efforts-well-intentioned2c-but-lacking.aspx

Gathers, D. (2003). Diversity management: An imperative for healthcare organizations. *Hospital Topics, 81*(3), 14-20.

GilDeane Group. (2005). The diversity council's best practices study. Seattle, WA: GilDeane Group. Retrieved from http://www.multiculturaladvantage.com

Goode, S., & Dixon, I. (2016). Are employee resource groups good for business? *Society for Human Resource Management*. Retrieved from https://www.shrm.org/hr-

today/news/hr-magazine/0916/pages/are-employee-resource-groups-good-for-business.aspx

Gotsis, G., & Grimani, K. (2016). Diversity as an aspect of effective leadership: Integrating and moving forward. *Leadership & Organization Development Journal, 37*(2), 241-264. doi:http://dx.doi.org/10.1108/LODJ-06-2014-0107

Gotsis, G., & Kortezi, Z. (2013). Ethical paradigms as potential foundations of diversity management initiatives in business organizations. *Journal of Organizational Change Management, 26*(6), 948-976. doi:10.1108/JOCM-11-2012-0183

Grachev, M., & Rakitsky, B. (2013). Historic horizons of Frederick Taylor's scientific management. *Journal of Management History, 19*(4), 512-527. doi:10.1108/JMH-05-2012-0043

Graham, L. D. (2013). Lillian Gilbreth's psychologically enriched scientific management of women consumers. *Journal of Historical Research in Marketing, 5*(3), 351-369. doi:10.1108/JHRM-02-2013-0009

Greasley, P. (2008). *Quantitative data analysis using SPSS: An introduction for health and social science.* Maidenhead: Open University Press.

Grensing-Pophal, L. (1999). Hiring to fit your corporate culture. *HRMagazine, 44*(8), 50-54.

Grant, S. (2010). Diversity in healthcare: Driven by leadership. *Frontiers of Health Services Management, 26*(3), 41-44; discussion 53-56.

Gulati, R., Mikhail, O., Morgan, R. O., & Sittig, D. F. (2016). Vision statement quality and organizational performance in U.S. hospitals. *Journal of Healthcare Management, 61*(5), 335-351.

Gündemir, S., Dovidio, J. F., Homan, A. C., & De Dreu, C. K. W. (2017). The impact of organizational diversity policies on minority employees' leadership self-perceptions and goals. *Journal of Leadership & Organizational Studies, 24*(2), 172-188. doi:10.1177/1548051816662615

Hansen, F. (2003). Diversity's business case doesn't add up. *Workforce, 82*(4), 28-32. Retrieved from ABI/INFORM Global database.

Harcourt, M., Lam, H., Harcourt, S., & Flynn, M. (2008). Discrimination in hiring against immigrants and ethnic minorities: the effect of unionization. *International Journal of Human Resource Management, 19*(1), 98-115. doi:10.1080/09585190701763958

Harnik, S. (2016). Lack of diversity among healthcare providers impacts healthcare disparities. *Center for Healthcare Innovation*. Retrieved from http://www.chisite.org/2016/06/09/lack-diversity-among-healthcare-providers-impacts-healthcare-disparity/

Haynes, M. C., Toof, R. A., Holmberg, M. D., & Bond, M. A. (2012). Diversification of the health care workforce: Six research propositions for future research. *International Journal of Diversity In Organisations, Communities & Nations, 11*(5), 163-173. doi:10.18848/1447-9532/CGP/v11i05/39044

Health Research & Educational Trust. (2015, June). *Equity of care: A toolkit for eliminating health care disparities*. Retrieved from http://www.diversityconnection.org/diversityconnection/membership/Resource%20Center%20Docs/equity-of-care-toolkit.pdf

Health Research & Educational Trust. (2016). *Diversity and disparities: A benchmarking study of U.S. hospitals in 2015*. Retrieved from http://www.diversityconnection.org/diversityconnection/leadership-conferences/2016%20Conference%20Docs%20and%20Images/Diverity_Disparities2016_final.pdf

Heilbrunn, E. (2014, November 5). *Top health insurance companies*. *U.S.News*. Retrieved from http://health.usnews.com/health-news/health-insurance/articles/2013/12/16/top-health-insurance-companies

Henkel, G. (2016). Does U.S. healthcare need more diverse leadership? *The Hospitalist*. Retrieved from http://www.the-hospitalist.org/hospitalist/article/121639/does-us-healthcare-need-more-diverse-leadership

Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2013). *Research design in counseling*. (3rd ed.). Belmont, CA: Cengage Learning.

Hill, A. D., Upadhyay, A. D., & Beekun, R. I. (2015). Do female and ethnically diverse executives endure inequity in the CEO position or do they benefit from their minority status? An empirical examination. *Strategic Management Journal, 36*(8), 1115-1134. doi:10.1002/smj.2274

Hiranandani, V. (2012). Diversity management in the Canadian workplace: Towards an antiracism approach. *Urban Studies Research, 2012*, 1-13. http://dx.doi.org/10.1155/2012/385806

Hite, L. M., & McDonald, K. S. (2006). Diversity training pitfalls and possibilities: An exploration of small and mid-size US organizations. *Human Resource Development International, 9*(3), 365-377. doi:10.1080/13678860600893565

Ho, G. W. (2017). Examining perceptions and attitudes: A review of Likert-Type scales versus Q-Methodology. *Western Journal of Nursing Research*, 39(5), 674-689. doi:10.1177/0193945916661302

Hoch, E. J. (2014). Shared leadership, diversity, and information sharing in teams. *Journal of Managerial Psychology, 29*(5), 541-564. doi:10.1108/jmp-02-2012-0053

Hoffman, L. R., & Maier, N. R. F. (1961). Quality and acceptance of problem solutions by members of homogeneous and heterogeneous groups. *The Journal of Abnormal and Social Psychology, 62*(2), 401-407. doi:10.1037/h0044025

Hollmer, M. (2016). For insurance industry, diversity remains elusive at the top. *Carrier management: Critical information for p/c carrier executives*. Retrieved from https://www.carriermanagement.com/

Horwitz, I. B., Marilyn, S., & Horwitz, S. K. (2011).Improving health care quality through culturally competent physicians: leadership and organizational diversity training. *Journal of Healthcare Leadership, 2011*(3), 29-40. doi:10.2147/JHL.S15620

Hunt, V., Layton, D., & Prince, S. (2014). *Diversity matters.* Retrieved from http://www.mckinsey.com/

Hur, Y., & Strickland, R. A. (2015). Diversity management practices, do they make a difference? Examining consequences of their adoption in local governments. *Public Administration Quarterly, 39*(2), 325-357.

Iglehart, J. K. (2014). Diversity dynamics — challenges to a representative U.S. medical workforce. *The New England Journal of Medicine, 371*, 1471-1474. doi:10.1056/NEJMp1408647

Ilmakunnas, P., & Ilmakunnas, S. (2011). Diversity at the workplace: whom does it benefit? *De Economist, 159*, 223-255.

Irizarry, C., & Gallant, L. (2006). Managing diversity: Interpretation and enactment in a health care setting. *Qualitative Research Reports In Communication, 7*(1), 43-50.

Iversen, G. (2004). Quantitative research. In M. Lewis-Beck, A. Bryman, & T. Liao (Eds.), *Encyclopedia of social science research methods.* (pp. 897-898). Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781412950589.n787

Jackson, S. E., Joshi, A., & Erhardt, N. L. (2003). Recent research on team and organizational diversity: SWOT analysis and implications. *Journal of Management, 29*, 801-830. doi:10.1016/S0149-2063_03_00080-1

Jayanthi, A. (2016). The new look of diversity in healthcare: Where we are and where we're headed. *Becker's Hospital Review*. Retrieved from http://www.beckershospitalreview.com/hospital-management-administration/the-new-look-of-diversity-in-healthcare-where-we-are-and-where-we-re-headed.html

Jayne, M. E. A., & Dipboye, R. L. (2004). Leveraging diversity to improve business performance: Research findings and recommendations for organizations. *Human Resource Management, 43*(4), 409-424. doi:10.1002/hrm.20033

Jin, M., Lee, J., & Lee, M. (2017). Does leadership matter in diversity management? assessing the relative impact of diversity policy and inclusive leadership in the public sector. *Leadership & Organization Development Journal, 38*(2), 303-319.

Johns, M. (2013). Breaking the glass ceiling: Structural, cultural, and organizational barriers preventing women from achieving senior and executive positions. *Perspectives in Health Information Management*, 1-11.

Johnson, S. K., & Sy, T. (2016, December 29). Why aren't there more Asian Americans in leadership positions? *Harvard Business Review*. Retrieved from https://hbr.org/2016/12/why-arent-there-more-asian-americans-in-leadership-positions

Joshi Pant, J., & Vijaya, V. (2015). Challenges in diversity management: A case study of MediHealth Systems. *South Asian Journal of Management, 22*(1), 159–186.

Jupp, V. (Ed.). (2006). *The SAGE dictionary of social research methods.* Thousand Oaks: SAGE Publications Ltd. doi: 10.4135/9780857020116

Jyoti, J., & Bhau, S. (2015). Impact of transformational leadership on job performance mediating role of leader–member exchange and relational identification. *SAGE Journals, 2015*, 1-13. doi:10.1177/2158244015612518

Kadi, A. S. (2014). An exploration of challenges facing Muslim Americans' advancement to leadership in the legal field. *Journal of Psychological Issues in Organizational Culture, 4*(4), 33-64. doi:10.1002/jpoc.21126

Kaiser Permanente. (2015). *Press release: Kaiser Permanente named no. 2 on DiversityInc's Top 50 Companies for Diversity® list for 2015*. Retrieved from https://share.kaiserpermanente.org/article/kaiser-permanente-named-no-2-on-diversityincs-top-50-companies-for-diversity-list-for-2015/

Kalev, A., Kelly, E., & Dobbin, F. (2006). Best practices or best guesses? Assessing the efficacy of corporate affirmative action and diversity policies. *American Sociological Review, 71*(4), 589-617. doi:10.1108/jmp-02-2012-0053

Kalra, V. S., Abel, P., & Esmail, A. (2009). Developing leadership interventions for Black and minority ethnic staff: A case study of the National Health Service (NHS) in the UK. *Journal of Health Organization and Management, 23*(1), 103-118. doi:10.1108/14777260910942588

Kameny, R. R., DeRosier, M. E., Taylor, L. C., McMillen, J. S., Knowles, M. M., & Pifer, K. (2013). Barriers to career success for minority researchers in the behavioral sciences. *Journal of Career Development, 41*(1), 43-61. doi:10.1177/0894845312472254

Katz, J. H., & Miller, F. A. (2016). Defining diversity and adapting inclusion strategies on a global scale. *OD Practitioner, 48*(3), 42–47.

Kay, F. M., & Gorman, E. H. (2012). Developmental practices, organizational culture, and minority representation in organizational leadership: The case of partners in large U.S. law firms. *The ANNALS of the American Academy of Political and Social Science, 639*(1), 91-113. doi:10.1177/0002716211420232

Keating, D., & Karklis, L. (2016, November 25). The increasingly diverse United States of America. *The Washington Post*. Retrieved from https://www.washingtonpost.com/graphics/national/how-diverse-is-america/

Khan, R., Bukhari, A., & Channar, Z. A. (2016). Effects of leadership style on health care organizational performance: A survey of selected tertiary care hospital in Karachi,

Pakistan. *International Journal of Economics & Management Sciences, 5*, 333. doi:10.4172/2162-6359.1000333

Kilpatrick, A. O. (2009). The health care leader as humanist. *Journal of Health and Human Services Administration, 31*(4), 451-65.

Kim, P. S. (1999). Globalization of human resource management: A cross-cultural perspective for the public sector. *Public Personnel Management, 28*(2), 227–243

Kim, T. H., Thompson, J. M., & Herbek, G. J. (2012). Organizational and market factors associated with leadership development programs in hospitals: A national study. *Journal of Healthcare Management, 57*(2), 113-132; discussion 131-2. doi:10.1097/00115514-201203000-00007

Kitroeff, N. (2018, May 4). Unemployment rate hits 3.9%, a rare low, as job market becomes more competitive. *The New York Times*. Retrieved from https://www.nytimes.com/

Klenke, K. (2016). *Qualitative research in the study of leadership*. Bingley, UK: Emerald Group Publishing.

Kogler Hill, S. E., & Gant, G. (2000). Mentoring by minorities for minorities: The organizational communications support program. *Review of Business, 21*(1), 53-57.

Kunze, F., Boehm, S., & Bruch, H. (2013). Organizational performance consequences of age diversity: Inspecting the role of diversity-friendly HR policies and top managers' negative age stereotypes. *Journal of Management Studies*, 50(3), 413-442. doi:10.1111/joms.12016

Kurtulus, F. A. (2012). Affirmative Action and the occupational advancement of minorities and women during 1973-2003. *Industrial Relations, 51*(2), 213-246. doi:10.1111/j.1468-232X.2012.00675.x

Lambertz-Berndt, M. M. (2016). Communicating identity in the workplace and affinity group spaces. *Studies in Media and Communication, 4*(2), 110-124. doi:10.11114/smc.v4i2.1952

Latham, S. D. (2014). Leadership research: An arts-informed perspective. *Journal of Management Inquiry, 23*(2), 123–132. doi:10.1177/1056492613491434

Law, C. (2012). *When diversity training isn't enough: The case for inclusive leadership*. Retrieved from https://www.deomi.org/EOEEOResources/documents/When_Diversity_Training_Isnt_Enough_Tech_Report_Law.pdf

Lavrakas, P. J. (Ed.). (2008). *Encyclopedia of survey research methods.* Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781412963947

Li, Y. (2015). *Expatriate manager's adaptation and knowledge acquisition: Personal development in multi-national companies in China*. Singapore, Singapore: Springer.

Mabey, C. (2012). Leadership development in organizations: Multiple discourses and diverse practice. *TOC, 15*(4), 359–380.

Marquardt, M. J. (2009). *Human resources and their development*. Oxford, UK: EOLSS Publications.

Marques, J. (2015). The changed leadership landscape: What matters today. *The Journal of Management Development, 34*(10), 1310-1322.

Martin, J., McCormack, B., Fitzsimons, D., & Spirig, R. (2014). The importance of inspiring a shared vision. *International Practice Development Journal, 4*(2). Retrieved from https://www.fons.org/Resources/Documents/Journal/Vol4No2/IPDJ_0402_04.pdf

Matus, J. C. (2003). The movement for diversity in health care management. *Health Care Manager, 22*(2):117-121.

Mazur, B. (2012). Building diverse and inclusive organizational culture-best practices: A case study of Cisco Co. *Journal of Intercultural Management, 6*(4), 169–179. doi:10.2478/joim-2014-0043

Mba, I. N., & Teresa, E. U. (2013). Diversity in the concept of management: Different style and difference ethics. *American Journal of Humanities and Social Sciences, 1*(3), 144-150. doi:10.11634/232907811301377

McAlearney, A. S., & Sinioris, M. (2010). Executive leadership development in U.S. health systems. *Journal of Healthcare Management, 55*(3), 206-22. Retrieved from http://www.ache.org

McDonagh, K. J., Bobrowski, P., Hoss, M. A. K., Paris, N. M., & Schulte, M. (2014). The leadership gap: Ensuring effective healthcare leadership requires inclusion of women at the top. *Open Journal of Leadership, 2014*(3), 20-29. doi:10.4236/ojl.2014.32003

McGregor, S. T., & Murnane, J. A. (2010). Paradigm, methodology and method: intellectual integrity in consumer scholarship. *International Journal of Consumer Studies, 34*(4), 419-427. doi:10.1111/j.1470-6431.2010.00883.x

McGrory, A. (2011). Few employers focus on diversity. *Benefits Selling.Breaking News.*

McMahon, A. M. (2010). Does workplace diversity matter? A survey of empirical studies on diversity and firm performance, 2000-09. *Journal of Diversity Management, 5*(2), 37-48. doi:10.19030/jdm.v5i2.808

McNabb, D. E. (2015). *Research methods for political science: Quantitative and qualitative methods.* New York, NY: Routledge.

Meeussen, L., Otten, S., & Phalet, K. (2014). Managing diversity: How leaders' multiculturalism and colorblindness affect work group functioning. *Group Processes and Intergroup Relations, 17*(5). Retrieved from http://journals.sagepub.com/doi/abs/10.1177/1368430214525809

Mendenhall, W., Beaver, R. J., & Beaver, B. M. (2012). *Introduction to probability and statistics.* Boston, MA: Cengage Learning.

Merriam, S. B., & Tisdell, E. J. (2015). *Qualitative research: A guide to design and implementation.* San Francisco, CA: John Wiley & Sons.

Mgbere, O. (2009). Exploring the relationship between organizational culture, leadership styles and corporate performance: An overview. *Journal of Strategic Management Education, 5*(3), 187-201. Retrieved from http://www.senatehall.com/strategic-management

Milkint, M. R. (2016). *The growing diversity and inclusion mandate.* The Jacobson Group. Retrieved from https://jacobsononline.com/

Mitchell, R., Boyle, B., Parker, V., Giles, M., Joyce, P., & Chiang, V. (2014). Transformation through tension: The moderating impact of negative affect on transformational leadership in teams. *Human Relations, 67*(9), 1095-1121. doi:10.1177/0018726714521645

Modern Healthcare. (2016). *CEOs look to jump-start stalled minority participation in C-suites, boardrooms*. Retrieved from http://www.modernhealthcare.com

Mora, M. (2012). *Research methodologies, innovations, and philosophies in software systems engineering and information systems*. Hershey, PA: IGI Global.

Mosadeghrad, A. M., & Ferdosi, M. (2013). Leadership, job satisfaction and organizational commitment in healthcare sector: Proposing and testing a model. *Mater Sociomed., 25*(2): 121–126. doi:10.5455/msm.2013.25.121-126

Mpofu, E., & Harley, D. A. (2006). Racial and disability identity: Implications for the career counseling of African Americans with disabilities. *Rehabilitation Counseling Bulletin, 50*(1), 14–23.

Munyeka, W. (2014). Employees' discernment of workforce diversity and its effect on job satisfaction in a public service department. *Mediterranean Journal of Social Sciences, 5*, 37-48. doi:10.5901/mjss.2014.v5n15p37

Murray, C. D. (2015). Barriers and challenges minority men and women experienced with senior executive service advancement. *Journal of Psychological Issues in Organizational Culture, 6*(1), 16-37. doi:10.1002/jpoc.21173

Mycroft, D. (2012). (Doctoral dissertation, Pepperdine University). Available from ProQuest Dissertations and Theses database. Retrieved from http://search.proquest.com

Naile, I., & Selesho, J. B. (2014). The role of leadership in employee motivation. *Mediterranean Journal of Social Sciences, 5*(3), 175-182. doi:10.5901/mjss.2014.v5n3p175

Narayana, C. N. (2013). Performance management for competitive advantage and leadership reflex. *International Journal of Strategic Management, 13*(1), 81-96. doi:10.18374/ijsm-13-1.9

Nahavandi, A. (2006). *The art and science of leadership* (4th ed.). Upper Saddle River, NJ: Pearson-Prentice Hall.

Nöhren, M. (2015). *Enterprise software sourcing performance: The impact logic of on-demand, on-premises, and in-house software on dynamic fit and process-level performance outcomes in client organizations*. New York: Springer.

Northouse, P. G. (2012). *Leadership: Theory and practice*. Washington, D.C.: SAGE.

Norton, M. B., Sheriff, C., Blight, D. W., Chudacoff, H., & Logevall, F. (2011). *A people and a nation: A history of the United States, brief edition, volume II: Since 1865*. Boston, MA: Cengage Learning.

O'Brien, P. M., & Bobick, T. A. (2012). Multiple choice. *Best's Review, 112*(10), 57-59.

O'Leonard, K., & Krider, L. (2014). *Leadership development factbook 2014: Benchmarks and trends in US leadership development*. Oakland, CA: Bersin & Associates.

Olsen, J. E., & Martins, L. L. (2012). Understanding organizational diversity management programs: A theoretical framework and directions for future research. *Journal of Organizational Behavior, 33*(8), 1168-1187. doi:10.1002/job.1792

Olson, B. J., Parayitam, S., & Twigg, N. W. (2006). Mediating role of strategic choice between top management team diversity and firm performance: Upper echelons theory revisited. *Journal of Business and Management, 12*(2), 111-126.

Ordu, A. (2016). The effects of diversity management on job satisfaction and individual performance of teachers. *Educational Research and Reviews, 11*(3), 105-112. doi:10.5897/ERR2015.2573

O'Reilly, C. A., III, Caldwell, D. F., & Barnett, W. P. (1989). Work group demography, social integration, and turnover. *Administrative Science Quarterly, 34*(1), 21.

Osbourne, J. W., & Waters, E. (2002). Four assumptions of multiple regression that researchers should always test. *Practical Assessment, Research & Evaluation, 8*(2), 1-5. Available from http://PAREonline.net/getvn.asp?v=8&n=2.

Packard, T., & Jones, L. (2015). An outcomes evaluation of a leadership development initiative. *Journal of Management Development, 34*(2), 153-168. doi:10.1108/JMD-05-2013-0063

Patrick, H. A., & Kumar, V. R. (2012). Managing workplace diversity: Issues and challenges. *SAGE Open*. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/2158244012444615

Pershing, S. P., & Austin, E. K. (2014). *Organization theory and governance for the 21st century*. Washington, D.C.: CQ Press.

Pfeffer, J., & Salancik, G. (1978). *The external control of organizations: A resource dependency perspective.* New York, NY: Harper and Row.

Phillips, D. C. (2014). *Encyclopedia of educational theory and philosophy*. Thousand Oaks, CA: SAGE.

Pitts, D. (2009). Diversity management, job satisfaction, and performance: Evidence from U.S. federal agencies. *Public Administration Review, 69*(2), 328–338.

Pleasant, S. (2017). Crossing the boundaries of employee engagement and workplace diversity and inclusion: Moving HRD forward in a complicated sociopolitical climate. *New Horizons in Adult Education & Human Resource Development, 29*(3), 38–44. doi:10.1002/nha3.20191

Rabl, T., María del, C. T., Seo-Young, B., & Bosch, L. (2018). Diversity management efforts as an ethical responsibility: How employees' perceptions of an organizational integration and learning approach to diversity affect employee behavior. *Journal of Business Ethics*, 1-20. doi:10.1007/s10551-018-3849-7

Rabl, T., & Triana, M. D. C. (2014). Organizational value for age diversity and potential applicants' organizational attraction: Individual attitudes matter. *Journal of Business Ethics, 121*(3), 403-417. doi:10.1007/s10551-013-1729-8

Randy, E. (2014). Peer collaboration ENHANCES diversity and inclusion. *Talent Development, 6*8(12), 48-52.

Rangarajan, N., & Black, T. (2007). Exploring organizational barriers to diversity: A case study of the New York State Education Department. *Review of Public Personnel Administration, 27*(3), 249-263. doi:10.1177/0734371x06296203

Rawat, S. R. (2015). Impact of transformational leadership over employee morale and motivation. *Indian Journal of Science and Technology, 8*(S6), 25–34. doi:10.17485/ijst/2015/v8is6/62118

Rea, L. M., & Parker, R. A. (2012). *Designing and conducting survey research: A comprehensive guide*. Hoboken, NJ: John Wiley & Sons.

Ribiere, V., & Worasinchai, L. (2013). *ICMLG2013-Proceedings of the International Conference on Management, Leadership and Governance: ICMLG 2013*. Reading, UK: Academic Conferences Limited.

Rich, V. L. (2013). Advancing diversity leadership in health care. *Nursing Administration Quarterly, 37*(3), 269-271. doi:10.1097/naq.0b013e318296923d

Richard, O. C. (2000). Racial diversity, business strategy, and firm performance: A resource-based view. *The Academy of Management Journal, 43*(2), 164-177. doi:10.2307/1556374

Rigolosi, E. L. M. (2012). *Management and leadership in nursing and health care: An experiential approach* (3d ed.). New York: Springer Publishing Company.

Roethlisberger, F. J., & Dickson, W. J. (1949). *Management and the worker*. Cambridge, MA: Harvard University Press.

Sabharwal, M. (2014). Is diversity management sufficient? Organizational inclusion to further performance. *Public Personnel Management, 43*(2), 197-217. doi:10.1177/0091026014522202

Salomon, M. F., & Schork, J. M. (2003). Turn diversity to your advantage. *Research Technology Management, 46*(4), 37. doi:10.1080/08956308.2003.11671575

Sania, U., Kalpina, K., & Javed, H. (2015). Diversity, employee morale and customer Sabharwal *Management, 3*(1), 11-18. doi:10.7763/JOEBM.2015.V3.147

Saxena, A. (2014). Workforce diversity: A key to improve productivity. *Procedia Economics and Finance, 11*, 76-85. https://doi.org/10.1016/S2212-5671(14)00178-6

Schneider, B., & Barbera, K. M. (2014). *The Oxford handbook of organizational climate and culture*. New York: Oxford University Press.

Schoja, V. (2016). *Determining consumer behavior in the catering industry: A case study of Starbucks UK.* Hamburg, Germany: Anchor Academic Publishing.

Scott, C. L. (2012). *Handbook of research on workforce diversity in a global society: Technologies and concepts*. Hershey, PA: IGI Global.

Sen, A., & Srivastava, M. (2012). *Regression analysis: Theory, methods, and applications.* New York: Springer Science & Business Media.

Sharma, A. (2016). Managing diversity and equality in the workplace. *Cogent Business & Management, 3*, 1212682. doi:10.1080/23311975.2016.1212682

Sharma, G. V., & Freeman, I. M. (2014). Mentoring: Why it matters even after training. *Journal of the American College of Cardiology, 64*(18), 1964–1965.

Sheldon, K., Davies, J., & Howells, K. (2012). *Research in practice for forensic professionals.* New York, NY: Routledge.

Shepherd, M. (2015). *Inductive reasoning testing guide: Sample test questions for inductive reasoning*. Ann Arbor, MI: ProQuest Dissertations.

Shore, L. M., Chung-Herrera, B. G., Dean, M. A., Ehrhart, K. H., Jung, D. I., Randel, A. E., & Singh, G. (2009). Diversity in organizations: Where are we now and where are we going? *Human Resource Management Review, 19*(2), 117-133. doi:10.1016/j.hrmr.2008.10.004.

Silver, R. (2017). Healthcare leadership's diversity paradox. *Leadership in Health Services, 30*(1), 68-75. doi:10.1108/LHS-02-2016-0007

Singal, M., & Gerde, V. W. (2015). Is diversity management related to financial performance in family firms? *Family Business Review.* doi:10.1177/0894486514566012

Smith, D. G., Turner, C. S., Osei-Kofi, N., & Richards, S. (2004). Interrupting the usual: successful strategies for hiring diverse faculty. *The Journal of Higher Education, 75*(2), 133-160. doi:10.1080/00221546.2004.11778900

Soylu, A., & Buchanan, T. A. (2013). Ethnic and racial discrimination against immigrants. *Journal of Business and Economics, 4*(9), 848-858.

Stanley, D. J. (2012). Clinical leadership and innovation. *Journal of Nursing Education and Practice, 2*(2), 119-126. doi:10.5430/jnep.v2n2p119

Steele, M., Fisman, S., & Davidson, B. (2012). Mentoring and role models in recruitment and retention: A study of junior medical faculty perceptions. *Medical Teacher, 35*(5), 1130-1138. doi:10.3109/0142159X.2012.735382

Statista. (2017). Percentage of population in the United States in 2014 and 2060, by race and Hispanic origin. Retrieved from whttps://www.statista.com/statistics/270272/percentage-of-us-population-by-ethnicities/

Sullivan, L. E. (2009). *The SAGE glossary of the social and behavioral sciences.* Thousand Oaks, CA: Sage Publications.

SurveyMonkey. (2017). Sample size calculator. Retrieved from https://www.surveymonkey.com/mp/sample-size-calculator/#

Swayne, L. E., Duncan, W. J., & Ginter, P. M. (2013). *Strategic management of health care organizations (7th ed.).* San Francisco, Calif: Jossey-Bass.

Taplin, S. H., Foster, M. K., & Shortell, S. M. (2013). Organizational leadership for building effective health care teams. *Annals of Family Medicine, 11*(3), 279-281. doi:10.1370/afm.1506

Thach, E. C. (2002). The impact of executive coaching and 360 feedback on leadership effectiveness. *Leadership & Organization Development Journal, 23*(4), 205-214. doi:10.1108/01437730210429070

Thomas, D. A. (2001). The truth about mentoring minorities: Race matters. *Harvard Business Review, 74*(5), 99-105.

Thomas, D. A., & Robin, J. E. (1996). Making differences matter: A new paradigm for managing diversity. *Harvard Business Review, 74*(5), 79-90.

Thompson, J., & Temple, A. (2015). Early careerist interest and participation in health care leadership development programs. *Health Care Manager, 34*(4), 350-358. doi:10.1097/HCM.0000000000000082

Thurber, S., & Kishi, Y. (2014). Coefficient alpha and interculture test selection. *Assessment, 21*(2), 250-252. doi:10.1177/1073191112444921

Trastek, V. F., Hamilton, N. W., & Niles, E. E. (2014). Leadership models in health care - a case for servant leadership. *Mayo Clin Proc., 89*(3), 374-81. doi:10.1016/j.mayocp.2013.10.012

Trenerry, B., Franklin, H., & Paradies, Y. (2012). *Preventing race-based discrimination and supporting cultural diversity in the workplace*. Melbourne: Victorian Health Promotion Foundation.

United States Census Bureau. (2013). About. Retrieved from http://www.census.gov/topics/population/race/about.html

Valentine, P., Wynn, J., & McLean, D. (2016). Improving diversity in the health professions. *North Caroline Medical Journal, 77*(2), 137-140. doi:10.18043/ncm.77.2.137

Valfort, M. A. (2017). 6. Combating anti-LGBTI discrimination. *OECD Social, Employment & Migration Working Papers*, (198), 118–125.

Van de Ven, A. H., Rogers, R. W., Bechara, J. P., & Kangyong, S. (2008). Organizational diversity, integration and performance. *Journal of Organizational Behavior, 29*(3), 335-354. doi:10.1002/job.511

Veiseh, S., Mohammadi, E., Pirzadian, M., & Sharafi, V. (2014). The relation between transformational leadership and organizational culture (Case study: Medical school of Ilam). *Journal of Business Studies Quarterly, 5*(3), 113-124.

Vega, T. (2015, November 25). Working while brown: What discrimination looks like now. *CNN*. Retrieved from http://money.cnn.com/2015/11/25/news/economy/racial-discrimination-work/

Versum Materials (2018). Versum Materials joins more than 400 CEOs in commitment to advance diversity and inclusion in the workplace. *Business Wire* (English). Retrieved from https://www.businesswire.com/news/home/20180521005043/en/Versum-Materials-Joins-400-CEOs-Commitment-Advance

Vogt, W. P. (2007). *Quantitative research methods for professionals*. Boston, MA: Allyn and Bacon.

Walker, C. L. (1989). Correlational research. *Journal of the Association of Pediatric Oncology Nurses, 6*(1), 21-22. doi:10.1177/104345428900600108

Wallner, P. E. (2008). (Doctoral dissertation, University of Phoenix). Available from ProQuest Dissertations and Theses database. Retrieved from http://search.proquest.com

Walter, M., & Andersen, A. (2013). *Indigenous statistics: A quantitative research methodology*. Walnut Creek, CA: Left Coast Press.

Wang, P., Rode, J. C., Shi, K., Luo, Z., & Chen, W. (2013). A workgroup climate perspective on the relationships among transformational leadership, workgroup diversity, and employee creativity. *Group & Organization Management, 38*(3), 334-360. doi:10.1177/1059601113488163

Warden, G. (1999). Leadership diversity. *Journal of Healthcare Management, 44*(6), 421-2. doi:10.1097/00115514-199911000-00003

Watson, W. E., Kumar, K., & Michaelsen, L. K. (1993). Cultural diversity's impact on interaction process and performance: Comparing homogeneous and diverse task groups. *Academy of Management Journal, 36*(3), 590-602. doi:10.2307/256593

Weller, S. C. (2015). Sample size estimation: The easy way. *Field Methods, 27*(4), 333-347. doi:10.1177/1525822X14530086

West, M. A., Lyubovnikova, J., Eckert, R., & Denis, J.-L. (2014). Collective leadership for cultures of high quality health care. *Journal of Organizational Effectiveness: People and Performance, 1*(3), 240-260. doi: 10.1108/JOEPP-07-2014-0039

Westphal, K. R. (2014). *Realism, science, and pragmatism*. New York, NY: Routledge.

Williams, D. A. (2013). *Strategic diversity leadership: Activating change and transformation in higher education*. Sterling, VA: Stylus Publishing, LLC.

Williams, C. L., Kilanski, K., & Muller, C. (2014). Corporate diversity programs and gender inequality in the oil and gas industry. *Work and Occupations, 41*(4), 440-476. doi: 10.1177/0730888414539172

Wilson, C. (2013). *Credible checklists and quality questionnaires: a user-centered design method*. Waltham, MA: Newnes.

Wilson, E. (2014). Diversity, culture and the glass ceiling. *Journal of Cultural Diversity, 21*(3), 83-9.

Wilson, A. J., & Kraus, C. N. (2014). Leadership development for organizational success. *SIOP*. Retrieved from http://www.siop.org/WhitePapers/Visibility/Leadership%20Development%20FINAL.pdf

Witt/Kieffer. (2015). Closing the gap in healthcare leadership diversity: A Witt/Kieffer study. Retrieved from http://www.wittkieffer.com

Wondrak, M., & Segert, A. (2015). Using the Diversity Impact Navigator to move from interventions towards diversity management strategies. *Journal of Intellectual Capital, 16*(1), 239-254. doi:10.1108/JIC-12-2013-0117

Wu, B. (2013). *New theory on leadership management science*. Oxford, UK: Chartridge Books Oxford.

Yost, D. M. (2014). Developing leaders in health care. *Association of Operating Room Nurses. AORN Journal, 100*(3), C5-C6. doi:10.1016/S0001-2092(14)00872-2

Zarya, V. (2016, March 30). These charts show exactly how few minority women are in positions of power. *Fortune*. Retrieved from http://fortune.com/2016/03/30/charts-minority-women-leaders/

Zayani, M. (2011). Media, cultural diversity and globalization: Challenges and opportunities. *Journal of Cultural Diversity*, *18*(2), 48–54.

Zirk-Sadowski, M., & Wojciechowski, B. (2016). *Towards recognition of minority groups: Legal and communication strategies.* London: Routledge.

Appendix A: Organizational Diversity Management Interventions Climate Assessment (ODMICA) Survey Instrument

Section 1: Demographics

| Questions | Response (Coding*) | | | |
|---|---|---|---|---|
| 1. Do you voluntarily agree to participate in the research study? | I Agree ( ) | | I Decline ( ) | |
| 2. Do you work for an American Firm? | Yes ( ) | | No ( ) | |
| 3. Type of industry you work in? | | | | |
| 4. Which department, business unit, or function do you work in (e.g., HR, EEO, Operations, Finance, Manufacturing Plant, Legal) | | | | |
| 5. Number of employees in the organization? [Make your best guess if you are not sure.] | | | | |
| 6. Number of male and female employees in your firm? [Make your best guess if not sure.] | Male: | | Female: | |
| 7. Number of people you supervise? | ( ) Directly | | ( ) Indirectly | |
| 8. Number of years of employment with this organization? | ( ) 2-5 | ( ) 6-9 | ( ) 10-15 | ( ) 16+ |
| 9. Age range of the respondent? | ( ) 25-30 | ( ) 31-40 | ( ) 41-50 | ( ) 51+ |
| 10. Educational Level? | ( ) Associates ( ) MBA/MS ( ) BA/BS<br>( ) DM/DBA/EdD ( ) Ph.D<br>( ) Other post graduate work<br>( ) Professional development<br>( ) No formal college degree | | | |
| 11. Gender of the respondent? | ( ) Male | | ( ) Female | |
| 12. Race of the respondent? | ( ) Asian ( ) Caucasian, not Hispanic<br>( ) Black (from U.S. Caribbean, Africa, Other)<br>( ) Hispanic ( ) All other groups | | | |
| 13. What is the race of your immediate supervisor? | ( ) Asian ( ) Caucasian, not Hispanic<br>( ) Black (from U.S. Caribbean, Africa, Other)<br>( ) Hispanic ( ) All other groups | | | |

| | |
|---|---|
| 14. Title of the respondent? | ( ) Senior Exec ( ) Senior Manager<br>( ) Director ( ) Middle Manager<br>( ) Supervisor ( ) Entry Level<br>( ) Team Leader |
| 15. Percentage of racial and ethnic minorities currently employed at the organization? [Make your best guess if you are not sure.] | ( %) Asians ( %) Blacks<br>( %) Caucasians ( %) Hispanics<br>( %) All other |

Section 2: Quantitative Survey: Assessing Leadership Advancement

| | Organizational Diversity Climate Inventory (ODCI) | | | | | |
|---|---|---|---|---|---|---|
| | | SD | D | N | A | SA |
| 16. | Diversity is a published value in my organization | | | | | |
| 17. | My organization solicits my ideas on the future of the organization | | | | | |
| 18. | My organization is slow to adopt diversity-related changes | | | | | |
| 19. | Diversity-related changes are effective in my organization | | | | | |
| 20. | My organization has a diversity task force in charge of diversity | | | | | |
| 21. | In my organization, the board is racially diverse | | | | | |
| 22. | Our senior leadership team is racially diverse (e.g., CEO, CFO, COO, CIO, Executive Vice Presidents, Vice Presidents, etc) | | | | | |
| 23. | My organization has at least one executive responsible for diversity | | | | | |
| 24. | Diversity initiatives improved the climate in my workplace | | | | | |
| 25. | There are in-house promotional opportunities for me | | | | | |
| 26. | Executive leadership positions are open to everyone | | | | | |
| 27. | African Americans occupy diversity-related jobs (e.g., EEO Officer) | | | | | |
| 28. | My organization attracts African Americans for entry-level positions | | | | | |
| 29. | Teamwork is a published value in my organization | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 30. | My business unit works in teams | | | | | |
| 31. | My organization empowers me to make decisions | | | | | |
| 32. | My organization promotes African American employees for team-leader roles | | | | | |
| 33. | Working in racially diverse teams greatly increases team conflict | | | | | |
| 34. | My organization recruits Hispanic Americans for team- leader roles | | | | | |
| 35. | My organization recruits Asian Americans for team-leader roles | | | | | |
| | Individual Satisfaction and Commitment Inventory (ISCI) [Satisfaction with the business unit, organization, supervisor, and peer relationships] | | | | | |
| 36. | I am passionate about my work (job content) | | | | | |
| 37. | I am satisfied with my organization (job context) | | | | | |
| 38. | I have a written career-development plan | | | | | |
| 39. | I am given explicit instructions from my supervisor to complete tasks | | | | | |
| 40. | I am satisfied with my compensation | | | | | |
| 41. | I have the skills I need to be promoted to the next level | | | | | |
| 42. | I know how to get ahead in my organization | | | | | |
| 43. | I can accomplish my personal career goals with my present firm | | | | | |
| 44. | I often assess my skill development needs | | | | | |
| 45. | I share a sense of camaraderie with the people in my business unit | | | | | |
| 46. | I am satisfied with the promotional opportunities in my organization | | | | | |
| 47. | I seek opportunities to work on challenging assignments | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 48. | I enjoy the cultural climate within my organization | | | | | |
| 49. | I receive positive feedback from my supervisor | | | | | |
| 50. | I volunteer for team assignments in my organization | | | | | |
| 51. | I am comfortable working in racially-diverse teams | | | | | |
| 52. | The leadership style in my organization is acceptable to me | | | | | |
| 53. | I am empowered to make decisions within my organization | | | | | |
| 54. | I practice my leadership skills within my job function | | | | | |
| 55. | I practice my leadership skills in circles outside the organization | | | | | |
| | Diversity Management Interventions Climate Inventory (DMICI) | | | | | |
| | Affinity Groups (same as Networks) [Groups formed by like-minded individuals or people of similar makeup to discuss generic issues.] | | | | | |
| 56. | There are formal affinity groups in my organization | | | | | |
| 57. | There are informal affinity groups in my organization | | | | | |
| 58. | Women form their own affinity groups | | | | | |
| 59. | In my organization affinity-group members get ahead | | | | | |
| 60. | External affinity groups are more productive for my career development needs | | | | | |
| 61. | African Americans get ahead when they are part of an affinity group | | | | | |
| 62. | I am a member of an internal affinity group | | | | | |
| 63. | I benefited from affinity groups | | | | | |
| 64. | Affinity group membership has been helpful to me in my organization | | | | | |
| | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Mentoring Programs<br><br>[Mentoring is a technique used to widen the social skills of capable and knowledgeable individuals who develop protégés] | | | | | |
| 65. | There is a formal mentoring program in my organization | | | | | |
| 66. | There is an informal mentoring program in my organization | | | | | |
| 67. | I benefited from mentoring programs sponsored by my organization | | | | | |
| 68. | Mentoring is a published value in my organization | | | | | |
| 69. | I am a mentor in my organization | | | | | |
| 70. | Employees who have mentors tend to get ahead in my organization | | | | | |
| 71. | Cross-racial mentoring is practiced within my organization | | | | | |
| 72. | I am proactive in seeking a mentor in my organization | | | | | |
| 73. | I only seek mentors from my own racial background | | | | | |
| 74. | I have at least one mentor outside my organization | | | | | |
| 75. | I can get ahead with the help of a mentor | | | | | |
| 76. | I benefited from a cross-racial mentor relationship | | | | | |
| 77. | I am willing to discuss career opportunities with my mentor | | | | | |
| | | | | | | |
| 78. | My organization has formal leadership training and development program(s) | | | | | |
| 79. | Training and development is a published value in my organization | | | | | |
| 80. | I am proactive in seeking out training and development opportunities | | | | | |
| 81. | Leadership training is available to all employees | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 82. | I encourage others to seek higher professional development | | | | | |
| 83. | I am proactive in assessing the needed skills for my job | | | | | |
| 84. | African Americans are proactive in their professional development in my organization | | | | | |
| 85. | Those who participate in training and development programs are more likely to get promoted | | | | | |
| 86. | My organization has diversity awareness training programs | | | | | |
| 87. | Diversity awareness training is mandatory for all employees | | | | | |
| 88. | I benefited from training and development programs sponsored by my organization | | | | | |

APPENDIX B: ADVERTISEMENT (ELECTRONIC)

**Diversity Management and Leadership Advancement Study**

Be part of an important research study on diversity management interventions

- Are you over the age of 18?
- Do you work in the health care insurance industry?
- Are you in a management, leadership, director, vice president, or executive role?

If you answered YES to these questions, you may be eligible to participate in a diversity management and leadership advancement research study.

The purpose of this research study is to assist with more effectively developing initiatives that may consequently impact diversity in management. The study is limited to 75 participants, who each will receive a Target gift card valued at $25.
The study is open to minorities who work in management and leadership positions within the health care insurance industry.

This study is being conducted online via Survey Monkey.

Please email XXXXXXXXXXXXX or call XXXXXXXXXXXXX for more information

## APPENDIX C: LETTER TO HEALTH CARE INSURANCE PROFESSIONALS

Dear Executive:

My name is Chester Brown. I am currently working on my dissertation, which is the final requirement to attain my Doctor of Management in Organizational Leadership degree at the University of Phoenix.

The dissertation project is a quantitative research study that analyzes data captured through an online survey administered on SurveyMonkey. The purpose of the study is to assist with more effectively developing initiatives that may consequently impact diversity in management.

Diversity management programs have become commonplace in many health care organizations within the United States. The spectrum of diversity programs range from diversity training to active recruitment and promotion of diverse talent to leadership positions. Minorities themselves also must be willing to seek and attain advancement positions to help facilitate diverse leadership.

Complete confidentiality and anonymity of participants will be maintained. Names and organizational information will not be used or released in the results or publications. . The research information collected in this study will be destroyed three (3) years after the completion of the study.

Participants will need to complete a consent form prior to taking the survey. The consent form gives permission to collect the online survey responses and to share results as part of the data analysis and findings. The consent form will be an introductory page before advancing to the actual online survey questions, which will be administered through SurveyMonkey <www.surveymonkey.com>. Participants can decline to participate from the study at any time prior to taking the study and during the survey process.

The 30-45 minute survey consists of questions divided into two sections. The first section will capture the demographics of the participant, including age, gender, ethnicity, and level of management. The second section assesses individual perceptions of the relationship of affinity groups, mentoring programs, training and development initiatives to the leadership advancement of minorities. This section will capture perceptions through 5-point scale of responses ranging from (1) strongly disagree to (5) strongly agree.

The survey is open to minorities working in management positions within the health care insurance industry. Minority is defined by 2013 United States Census Bureau standards as Blacks or African Americans, American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and Some Other Race.

The data collection period is April 1, 2018 to May 2, 2018. The study is voluntary and

respondents can withdraw at any time. The results of the research will be published in the form of a dissertation.

The study is open to 75 participants, who each will receive a $25 Target gift card.

For those interested in participating in the study can do so by going to: <www.surveymonkey.com>.

For further information on the study or if individuals are interested in participating in the survey, please contact me at XXXXXXXXXXXXX or XXXXXXXXXXXXX.

Thank you in advance for your participation.

Thank you,

Chester N. Brown Jr.

## APPENDIX D: INFORMED CONSENT (ELECTRONIC)

My name is Chester Brown, Jr. and I am a doctoral candidate at the University of Phoenix, School of Advanced Studies, pursuing a Doctor of Management in Organizational Leadership. I have received Academic and Internal Review Board approval to conduct research for a study entitled The Relationship of Diversity Management Interventions on Leadership Advancement of Minorities in Health Care Insurance Organizations.

The purpose of the study is to assist with more effectively developing initiatives that may consequently impact diversity in management.

Your participation is voluntary and will involve completion of an online survey consisting of 88 questions, which may take 45 minutes to complete. You can decide to be a part of this study or not. Once you start, you can withdraw from the study at any time without any penalty or loss of benefits. The results of the research study may be published but your identity will remain confidential and your name will not be made known to any outside party.

In this research, there are no foreseeable risks as the survey responses will not be connected to any personal identifiers. At the end of the survey, you will be instructed on how to receive a $25 Target card for completion of the study.

Respondent Agreement:

I agree to participate in the research study and acknowledge the following:

- Participants must be 18 years of age or older, work in the health care insurance industry, and hold a management or leadership position (e.g., manager, director, vice president, president chief executive).
- Participation is voluntary. I am free to withdraw consent and discontinue participation in this study at any time.
- Research information collected during this study, the list of respondents, and organizational identity will remain confidential.
- Study identification is anonymous and at no time am I required to identify myself or my organization.
- The research survey will be administered through SurveyMonkey. Information on SurveyMonkey's privacy policy can be found at https://www.surveymonkey.com/mp/policy/privacy-policy/
- The survey will not contain any demographic identifiers outside of race, gender, age, and position title.
- Survey data is stored on SurveyMonkey's servers in the United States.
- The research will retrieve data from SurveyMonkey at the conclusion of the participation period. The data and information collected will only be available to the researcher and University of Phoenix IRB. Data will be destroyed after three years from completion of the study.

- The researcher will publish results of the study in the form of a dissertation. Your identity will remain confidential and your name will not be made known to any outside party.
- Chester Brown, Jr is the researcher for this study. If you have any questions or concerns prior to agreeing or at any time during and after the study, you may contact Chester Brown at XXXXXXXXXXXXX or via email at XXXXXXXXXXXXX. For questions about your rights as a study participant, or any concerns or complaints, please contact the University of Phoenix Institutional Review Board via email at IRB@phoenix.edu.

Clicking on the “agree” button below indicates that you understand the nature of the study, the potential risks as a participant, and the means by which your identity will be kept confidential. This means that you are 18 years old or older and that you give your permission to volunteer as a participant in the study that is described here

If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button. During the survey process, participants can opt of the survey by not completing the full survey by the end of the survey period, May 2, 2018.

## APPENDIX E: THANK YOU ACKNOWLEDGEMENT (ELECTRONIC)

Thank you for taking the time to complete this survey. We truly value the information you have provided.

As a Thank You for participating in this survey, we would like to offer you a $25 Target gift card. To facilitate this, please provide us with a valid email address to send the gift card. You can do so by sending an email by 30 days after the end of the survey period (May 2, 2018) to XXXXXXXXXXXXX and putting « Completed Management Survey » in the Subject line of the email and providing a first and last name and valid email address in the body of the email. To protect privacy, confidentiality, and anonymity, do not communicate any other information in the email.

If you have any comments on the survey or would like to follow up on progress of the study, please email XXXXXXXXXXXXX.

## APPENDIX F: RESULTS TABLES

Table 13

*Correlations: Affinity groups, mentoring programs, and training and development*

| | | Affinity Groups | Mentoring | Training |
|---|---|---|---|---|
| Affinity Groups | Spearman's rho | 1 | .428** | .378** |
| | Sig. (2-tailed) | | .000 | .001 |
| | N | 72 | 70 | 72 |
| Mentoring | Spearman's rho | .428** | 1 | .514** |
| | Sig. (2-tailed) | .000 | | .000 |
| | N | 70 | 73 | 73 |
| Training | Spearman's rho | .378** | .514** | 1 |
| | Sig. (2-tailed) | .001 | .000 | |
| | N | 72 | 73 | 75 |

**. Correlation is significant at the 0.01 level (2-tailed).

Table 14

*Coefficients: Affinity groups, mentoring programs, and training and development*

| Model | | Unstandardized B | Coefficients Std. Error | Standardized Coefficients Beta | t | Sig. |
|---|---|---|---|---|---|---|
| 1 | (Constant) | 4.361 | 12.683 | | .344 | .732 |
| | Affinity Groups | .154 | .217 | .072 | .708 | .482 |
| | Mentoring | .025 | .260 | .010 | .095 | .925 |
| | Training | 1.678 | .294 | .627 | 15.716 | .000 |

Table 15

*Survey results for independent variable: Affinity groups*

| | | Q56 | Q57 | Q58 | Q59 | Q60 | Q61 | Q62 | Q63 | Q64 |
|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 75 | 75 | 74 | 75 | 75 | 75 | 75 | 73 | 75 |
| | Missing | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 |
| Mean | | 3.68 | 3.77 | 3.82 | 3.64 | 3.64 | 3.53 | 3.56 | 3.62 | 3.72 |
| Std. Error of Mean | | .099 | .122 | .111 | .096 | .112 | .111 | .129 | .127 | .118 |
| Median | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 |
| Mode | | 4 | 4 | 4 | 4 | 4 | 4 | 3[a] | 4 | 4 |
| Std. Deviation | | .857 | 1.060 | .956 | .832 | .968 | .963 | 1.118 | 1.088 | 1.021 |
| Variance | | .734 | 1.124 | .914 | .693 | .936 | .928 | 1.250 | 1.184 | 1.042 |
| Skewness | | -.781 | -.578 | -.410 | -.244 | -.225 | -.610 | -.363 | -.574 | -.895 |
| Std. Error of Skewness | | .277 | .277 | .279 | .277 | .277 | .277 | .277 | .281 | .277 |
| Kurtosis | | -.011 | -.569 | -.729 | .332 | -.873 | .388 | -.607 | -.290 | .510 |
| Std. Error of Kurtosis | | .548 | .548 | .552 | .548 | .548 | .548 | .548 | .555 | .548 |
| Range | | 3.0 | 4.0 | 3.0 | 4.0 | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Minimum | | 2.0 | 1.0 | 2.0 | 1.0 | 2.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |

a. Multiple modes exist. The smallest value is shown

Table 16

*Survey results for independent variable: Mentoring programs*

| | | Q65 | Q66 | Q67 | Q68 | Q69 | Q70 | Q71 | Q72 | Q73 | Q74 | Q75 | Q76 | Q77 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 | 74 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 74 | 75 |
| | Missing | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Mean | | 3.84 | 3.27 | 3.87 | 3.81 | 3.83 | 4.05 | 3.47 | 3.63 | 2.88 | 3.83 | 3.97 | 3.43 | 4.12 |
| Std. Error of Mean | | .109 | .133 | .108 | .112 | .111 | .085 | .128 | .110 | .136 | .124 | .085 | .150 | .089 |
| Median | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 3.00 | 4.00 | 4.00 | 4.00 | 4.00 |
| Mode | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Std. Deviation | | .945 | 1.155 | .935 | .961 | .964 | .733 | 1.107 | .955 | 1.174 | 1.070 | .735 | 1.294 | .770 |
| Variance | | .893 | 1.333 | .874 | .923 | .929 | .538 | 1.225 | .913 | 1.377 | 1.145 | .540 | 1.673 | .594 |
| Skewness | | -1.053 | -.490 | -.747 | -.751 | -.479 | -.295 | -.344 | -.517 | -.122 | -1.207 | -.588 | -.471 | -.575 |
| Std. Error of Skewness | | .277 | .277 | .277 | .279 | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .279 | .277 |
| Kurtosis | | 1.154 | -.657 | .322 | .151 | -.661 | -.433 | -.669 | .174 | -1.060 | 1.275 | .598 | -.952 | -.035 |
| Std. Error of Kurtosis | | .548 | .548 | .548 | .552 | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .552 | .548 |
| Range | | 4.0 | 4.0 | 4.0 | 4.0 | 3.0 | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 | 3.0 | 4.0 | 3.0 |
| Minimum | | 1.0 | 1.0 | 1.0 | 1.0 | 2.0 | 2.0 | 1.0 | 1.0 | 1.0 | 1.0 | 2.0 | 1.0 | 2.0 |
| Maximum | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |

Table 17

*Survey results for independent variable: Training and development*

| | | Q78 | Q79 | Q80 | Q81 | Q82 | Q83 | Q84 | Q85 | Q86 | Q87 | Q88 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| | Missing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mean | | 3.99 | 4.08 | 4.12 | 4.05 | 3.99 | 4.08 | 3.25 | 3.91 | 3.47 | 3.27 | 3.99 |
| Std. Error of Mean | | .058 | .086 | .085 | .098 | .084 | .080 | .137 | .091 | .136 | .144 | .101 |
| Median | | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 3.00 | 4.00 |
| Mode | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 |
| Std. Deviation | | .507 | .749 | .734 | .853 | .726 | .693 | 1.187 | .791 | 1.178 | 1.245 | .878 |
| Variance | | .257 | .561 | .539 | .727 | .527 | .480 | 1.408 | .626 | 1.387 | 1.550 | .770 |
| Skewness | | -.667 | -.330 | -.403 | -.641 | -.633 | -.358 | -.411 | -.167 | -.530 | -.397 | -.837 |
| Std. Error of Skewness | | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 |
| Kurtosis | | 3.697 | -.537 | -.353 | -.152 | .783 | .015 | -.829 | -.647 | -.463 | -.797 | .897 |
| Std. Error of Kurtosis | | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 |
| Range | | 3.0 | 3.0 | 3.0 | 3.0 | 3.0 | 3.0 | 4.0 | 3.0 | 4.0 | 4.0 | 4.0 |
| Minimum | | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 2.0 | 1.0 | 2.0 | 1.0 | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |

Table 18

*Survey results for organizational diversity capacity: Values*

| | | Q29 |
|---|---|---|
| N | Valid | 75 |
| | Missing | 0 |
| Mean | | 3.91 |
| Std. Error of Mean | | .104 |
| Median | | 4.00 |
| Mode | | 4 |
| Std. Deviation | | .903 |
| Variance | | .815 |
| Skewness | | -.604 |
| Std. Error of Skewness | | .277 |
| Kurtosis | | -.264 |
| Std. Error of Kurtosis | | .548 |
| Range | | 3.0 |
| Minimum | | 2.0 |
| Maximum | | 5.0 |

Table 19

*Survey results for organizational diversity capacity: Organizational culture*

| | | Q18 | Q19 | Q24 | Q30 | Q33 | Q37 | Q40 | Q48 | Q52 |
|---|---|---|---|---|---|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 |
| | Missing | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mean | | 3.44 | 3.33 | 3.15 | 3.92 | 3.44 | 3.48 | 3.32 | 3.64 | 3.69 |
| Std. Error of Mean | | .126 | .119 | .139 | .096 | .136 | .118 | .109 | .121 | .126 |
| Median | | 3.00 | 3.00 | 3.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 | 4.00 |
| Mode | | 4 | 4 | 2 | 4 | 4 | 4 | 4 | 4 | 4 |
| Std. Deviation | | 1.093 | 1.031 | 1.205 | .834 | 1.177 | 1.018 | .947 | 1.048 | 1.090 |
| Variance | | 1.196 | 1.063 | 1.451 | .696 | 1.385 | 1.037 | .896 | 1.098 | 1.188 |
| Skewness | | -.066 | -.031 | .091 | -.994 | -.619 | -.457 | -.493 | -.455 | -.706 |
| Std. Error of Skewness | | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 | .277 |
| Kurtosis | | -1.072 | -.935 | -1.008 | 1.612 | -.535 | -.471 | -.516 | -.402 | -.139 |
| Std. Error of Kurtosis | | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 | .548 |
| Range | | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Minimum | | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |

Table 20

*Survey results for organizational diversity capacity: Hiring and promotion practices*

| | | Q25 | Q27 | Q28 | Q32 | Q34 | Q35 |
|---|---|---|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 | 75 | 75 | 75 |
| | Missing | 0 | 0 | 0 | 0 | 0 | 0 |
| Mean | | 3.72 | 2.99 | 2.89 | 2.76 | 2.84 | 3.53 |
| Std. Error of Mean | | .096 | .151 | .156 | .162 | .155 | .118 |
| Median | | 4.00 | 3.00 | 3.00 | 3.00 | 3.00 | 4.00 |
| Mode | | 4 | 4 | 4 | 1 | 4 | 4 |
| Std. Deviation | | .831 | 1.310 | 1.351 | 1.403 | 1.346 | 1.018 |
| Variance | | .691 | 1.716 | 1.826 | 1.969 | 1.812 | 1.036 |
| Skewness | | -.445 | -.086 | -.004 | .171 | -.110 | -.606 |
| Std. Error of Skewness | | .277 | .277 | .277 | .277 | .277 | .277 |
| Kurtosis | | -.181 | -1.124 | -1.199 | -1.311 | -1.273 | .306 |
| Std. Error of Kurtosis | | .548 | .548 | .548 | .548 | .548 | .548 |
| Range | | 3.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| Minimum | | 2.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 | 5.0 |

Table 21

*Survey results for organizational diversity capacity: Employee engagement*

| | | Q17 | Q31 |
|---|---|---|---|
| N | Valid | 75 | 75 |
| | Missing | 0 | 0 |
| Mean | | 3.60 | 3.59 |
| Std. Error of Mean | | .091 | .101 |
| Median | | 4.00 | 4.00 |
| Mode | | 4 | 4 |
| Std. Deviation | | .788 | .871 |
| Variance | | .622 | .759 |
| Skewness | | -.340 | -.840 |
| Std. Error of Skewness | | .277 | .277 |
| Kurtosis | | .694 | .917 |
| Std. Error of Kurtosis | | .548 | .548 |
| Range | | 4.0 | 4.0 |
| Minimum | | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 |

Table 22

*Survey results for individual leadership readiness: Interpersonal skills*

| | | Q39 |
|---|---|---|
| N | Valid | 75 |
| | Missing | 0 |
| Mean | | 3.89 |
| Std. Error of Mean | | .105 |
| Median | | 4.00 |
| Mode | | 4 |
| Std. Deviation | | .909 |
| Variance | | .826 |
| Skewness | | -.561 |
| Std. Error of Skewness | | .277 |
| Kurtosis | | .156 |
| Std. Error of Kurtosis | | .548 |
| Range | | 4.0 |
| Minimum | | 1.0 |
| Maximum | | 5.0 |

Table 23

*Survey results for individual leadership readiness: Competency*

| | | Q42 | Q49 | Q54 |
|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 |
| | Missing | 0 | 0 | 0 |
| Mean | | 4.05 | 3.79 | 3.93 |
| Std. Error of Mean | | .080 | .083 | .096 |
| Median | | 4.00 | 4.00 | 4.00 |
| Mode | | 4 | 4 | 4 |
| Std. Deviation | | .695 | .722 | .827 |
| Variance | | .484 | .521 | .685 |
| Skewness | | -.319 | -.316 | -1.050 |
| Std. Error of Skewness | | .277 | .277 | .277 |
| Kurtosis | | -.053 | .108 | 1.821 |
| Std. Error of Kurtosis | | .548 | .548 | .548 |
| Range | | 3.0 | 3.0 | 4.0 |
| Minimum | | 2.0 | 2.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 |

Table 24

Survey results for individual leadership readiness: Commitment

| | | Q36 | Q43 | Q46 |
|---|---|---|---|---|
| N | Valid | 75 | 75 | 75 |
| | Missing | 0 | 0 | 0 |
| Mean | | 3.77 | 3.72 | 3.68 |
| Std. Error of Mean | | .088 | .103 | .1136 |
| Median | | 4.00 | 4.00 | 4.00 |
| Mode | | 4 | 4 | 4 |
| Std. Deviation | | .764 | .894 | .975 |
| Variance | | .583 | .799 | .950 |
| Skewness | | -1.085 | -.577 | -.570 |
| Std. Error of Skewness | | .277 | .277 | .277 |
| Kurtosis | | 2.132 | .260 | .142 |
| Std. Error of Kurtosis | | .548 | .548 | .548 |
| Range | | 4.0 | 4.0 | 4.0 |
| Minimum | | 1.0 | 1.0 | 1.0 |
| Maximum | | 5.0 | 5.0 | 5.0 |

Table 25

*Survey results for leadership advancement: Age of respondent*

| Age range | Mean | N | Std. Deviation |
|---|---|---|---|
| 25 – 30 | 86.9412 | 17 | 11.72855 |
| 31 – 40 | 88.6061 | 33 | 10.51766 |
| 41 – 50 | 88.1000 | 20 | 12.53584 |
| 51+ | 88.4000 | 5 | 16.14930 |

Table 26

*Survey results for leadership advancement: Gender of respondent*

| Gender | Mean | N | Std. Deviation |
|---|---|---|---|
| Female | 87.4667 | 15 | 17.50048 |
| Male | 88.2333 | 60 | 9.66098 |

Table 27

*Survey results for leadership advancement: Race of respondent*

| Race | Mean | N | Std. Deviation |
|---|---|---|---|
| Asian | 90.4333 | 30 | 10.45411 |
| Black | 82.6429 | 28 | 11.63397 |
| Hispanic | 91.5714 | 14 | 10.08208 |
| All other groups | 99.0000 | 3 | 8.18535 |

Table 28

Survey results for leadership advancement: Race, Gender, and Age of respondent

| Race | Gender | Age | Mean | N | Std. Deviation |
|---|---|---|---|---|---|
| Asian | Male | 25-30 | 91.5714 | 7 | 12.42118 |
| | | 31-40 | 90.9167 | 12 | 9.15978 |
| | | 41-50 | 83.8000 | 5 | 5.44977 |
| | Female | 25-30 | 91.5000 | 2 | 12.02082 |
| | | 31-40 | 75.0000 | 1 | . |
| | | 41-50 | 101.3333 | 3 | 10.69268 |
| Black | Male | 25-30 | 83.0000 | 5 | 5.52268 |
| | | 31-40 | 87.2857 | 7 | 3.77334 |
| | | 41-50 | 79.6000 | 5 | 6.06630 |
| | | 51+ | 83.3333 | 3 | 20.59935 |
| | Female | 25-30 | 79.6667 | 3 | 17.03917 |
| | | 31-40 | 86.3333 | 3 | 25.73584 |
| | | 41-50 | 71.0000 | 2 | 2.82843 |
| Hispanic | Male | 31-40 | 84.4286 | 7 | 7.63451 |
| | | 41-50 | 97.2500 | 4 | 5.90903 |
| | | 51+ | 96.0000 | 2 | 1.41421 |
| | Female | 41-50 | 110.0000 | 1 | . |
| All other groups | Male | 31-40 | 99.0000 | 3 | 8.18535 |