HEALTHY DIVERSITY:

PRACTICES THAT SUPPORT DIVERSE STAFFING IN COMMUNITY HEALTH CENTERS

UMASS LOWELL

Center for Women & Work
UMass Lowell

CENTER FOR WOMEN & WORK
UNIVERSITY OF MASSACHUSETTS LOWELL

Research Team:
Meg A. Bond
Michelle C. Haynes
Robin A. Toof
Michelle D. Holmberg
Johana Reyes Quinteros

Research Team

Meg A. Bond, Principal Investigator (Psychology, Center for Women & Work)
Michelle C. Haynes, Co-PI (Psychology, Center for Women & Work)
Robin A. Toof, Co-PI (Center for Family, Work & Community)
Michelle D. Holmberg, Project Manager Phase II
Lauren Hajjar, Project Manager Phase I
Johana Reyes-Quinteros, Graduate Research Assistant
Tracey Jackson, Graduate Research Assistant
Michelle Thompson, Undergraduate Research Assistant

Advisory Board

Dorcas Grigg-Saito, Chief Executive Officer, Lowell Community Health Center
Mary Leary, Program and Policy Analyst, Massachusetts League of Community Health Centers
Angela Nannini, Associate Professor, Department of Nursing, University of Massachusetts Lowell
Laura Punnett, Professor, Department of Work Environment, University of Massachusetts Lowell
Craig Slatin, Professor, Department of Community Health & Sustainability, University of Massachusetts Lowell

Lead Organization

Center for Women & Work, University of Massachusetts Lowell
The lead center supporting this action research project is the Center for Women & Work (CWW) at the University of Massachusetts Lowell. CWW is a vibrant community of scholars—representing diverse disciplines—who are dedicated to advancing knowledge about gender and work through research, enhancing understanding of this relationship through education and training, and challenging inequalities, particularly through institutional change. CWW is committed to addressing how the intersections of gender, ethnicity, race, and culture affect workplace dynamics.

Research Partner

Center for Family, Work & Community, University of Massachusetts Lowell
The project was done in partnership with the Center for Family, Work & Community (CFWC) at the University of Massachusetts Lowell. CFWC is committed to promoting healthy, productive, and sustainable communities by identifying needs and opportunities in the community and on campus and addressing them through research, technical assistance, program development, partnership formation, and funding from public and private sources.

Community Partner

The Massachusetts League of Community Health Centers
The Massachusetts League of Community Health Centers, established in 1972, is a statewide, non-profit association that serves the needs of the CHCs through training and education for clinicians, administrators, and board members; support for the expansion of health access; and guidance for the recruitment and sustainability of a workforce. Additionally, the Mass League represents CHCs by acting as a source of information for policymakers and the media. The Mass League was a critical partner in this research project, providing guidance and input at all stages of the process.

Funders

The primary funder for the Healthy Diversity Project was the **Society for the Psychological Study of Social Issues** (SPSSI). SPSSI is a professional associate that promotes the application of research on psychology aspects of important social issues to public policy solutions. The research was also supported by the **University of Massachusetts Lowell, Office of the Vice Provost for Research and Department of Psychology.**

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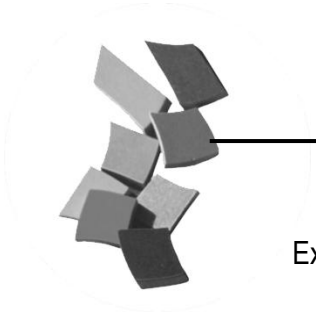

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Executive Summary

Our country is grappling with a health care crisis that has rendered quality services out of reach for many people, evidenced by troubling health disparities across ethnic, racial, and socioeconomic lines. One of the critical and intransigent barriers to accessing quality health care involves the mismatch between the ethnic/racial diversity of the U.S. population and that of the health care workforce. Community health centers (CHCs) have been at the forefront in providing culturally responsive care to ethnically/racially diverse communities across the country. This work requires attention to ethnic/racial diversity at all levels of health care organizations. While CHCs have been committed to hiring from their ethnically and culturally diverse local communities, they encounter unique challenges. It is also the CHCs' strong commitment to the community that has pushed them to find innovative ways to build and support diverse workforces. CHCs are uniquely poised to provide insights that can suggest lessons for other health and human service organizations.

Methodology

To identify and better understand challenges and best practices and to cull recommendations, we developed, in partnership with the Massachusetts League of Community Health Centers, a two-part survey that was sent to all 52 CHC members of the Mass League. The first part addressed issues around recruiting and retaining a diverse workforce; the second part assessed demographics for both patients and staff. A total of 25 CHCs (48% response rate) completed at least one portion of survey. Follow-up interviews were conducted with executive directors and/or human resources managers in 10 federally qualified CHC's.

Findings

The CHCs we surveyed employ an average of 47.2% White/non Hispanic workers, 20.4% Hispanics/Latinos, 14.9% black/non Hispanic, and 10.5% Asian. CHCs are largely staffed by females (averaging 78% across all centers), yet men were 6% more likely than women to hold higher level positions. More important than overall demographics is the extent to which the ethnic/racial demographic composition of each CHC workforce *matches* the demographic composition of the population they serve. To capture *match*, we developed a measure that assessed how well staffing paralleled patients for the top two demographics groups served. We found that demographic *match* between patients and staff is quite strong in most CHCs. Twelve centers had *excellent match,* where the top two demographic groups of patients were the same as the top two demographic groups in the workforce, in the same order. Three centers had a *match* (the top two demographic groups were the same but not in the same rank order), and 8 centers had a *match of one* (where only one of the top demographic groups of patients matched the top demographic group of the workforce).

Both the survey and interviews confirmed that CHC directors and managers value diversity in their workforce. All centers reported having invested time and energy into ensuring representation of ethnic/racial minority staff at all levels. Furthermore, the participating CHCs acknowledged that they need to continue their efforts and have taken some positive steps by identifying major challenges to recruiting and retaining a diverse workforce as well as by targeting opportunities to further foster inclusive work environments.

The following table highlights what representatives of participating centers shared about challenges and best practices in the areas of recruitment, staff development, work relations, and workplace environment practices. It is followed by a summary of recommendations directed to individual CHCs, the Massachusetts League of Community Health Centers, and/or state-level policy makers.

	Challenges	Promising Practices
Recruitment	• Limited opportunities for local community members to develop primary job skills • Difficulty identifying qualified culturally diverse applicants for medical & leadership positions • Competition with hospitals when recruiting for diversity • Limited recruitment budgets • Extra challenges in staffing for *match* when patient population is highly diverse	• Hiring for potential, then providing support to meet that potential • Utilizing specialized and targeted pipelines for recruitment of diverse professionals • Promoting from within to increase diverse representation throughout the workforce
Staff Development	• Limited CHC resources to develop existing workers • Stressors in lives of local community workforce • Scheduling and logistical barriers facing workers seeking further formal education	• Providing training & mentoring to support diverse staff • Accommodating barriers inherent in staff members' personal lives • Establishing partnerships with colleges and universities
Interactional & Work Relations	• Interpersonal misunderstandings at work based in cultural differences • Culturally varied health practices among staff • Interpersonal misunderstandings related to language issues • Relationships outside of work complicating work relationships	• Proactively recognizing potential role of culture in interpersonal misunderstandings among staff • Establishing settings that facilitate communication and promote inclusion for all staff • Providing training related to interpersonal relations at work
Workplace Environment	• Staffing practices that support diversity sometimes seem in conflict with attending to immediate needs • Definitions of "fair" or "doing good" not always supportive of diverse staff • Well-intended approaches can have unintended consequences	• Actively recognizing differences & multiple realities among staff • Avoiding becoming a "blaming organization" by considering context • Promoting an organizational culture of connection • Holding people accountable for impact on others (vs. their intentions) • Adopting a priority for *equitable* (vs. allowing "equal" to mean "identical") in policy development • Adopting savvy business practices to support diversity

Please see pages 19 to 29 in the full report for more detail.

Recommendations

- **Increase supports for recruitment**
  - Broaden coordination and support among CHCs and from the Mass League in posting jobs in ways that will reach ethnic/minority communities
  - Expand dissemination of information about external recruitment resources for leadership positions
  - Strengthen and coordinate relationships with educational institutions to foster an ongoing diversity pipeline for CHC personnel – even reach beyond Massachusetts in this effort
  - Expand the use of employee referral programs
- **Establish user-friendly systems for tracking staffing demographics and progress on diversity goals**
  - Standardize formats for reporting staff demographics across funders and accrediting bodies
  - Support and build on the Mass League's efforts to track vital CHC information about staffing demographics and professional development needs
  - Encourage funders to regularly include staffing issues alongside patient-centered issues in all requests for proposals
  - Actively disseminate strategies for establishing goals and tracking progress on efforts to enhance workforce-patient *match*
  - Address misconceptions about the legality of documenting staff demographics and recognize implications of the fact that ethnic/racial self-identification is voluntary for both staff and patients
  - Balance efforts to set goals and track progress with awareness of the challenges in addressing demographic *match* between staff and patients
- **Expand supports for staff training (within centers, statewide, regionally, and nationally)**
  - Offer ongoing training for supervisors, particularly around skills for managing a diverse workforce – beyond one-shot workshops
  - Encourage CHCs to offer regular training and support to enhance all staff's ability to work effectively across cultural, racial, gender, and sexual orientation differences
  - Expand language-based training and work on offering certification for medical interpretation
  - Explore ways to make English language training that focuses on both oral and written language skills more widely accessible
  - Advocate for more funding to support training and coordinate funding efforts

- ❖ Coordinate to enhance proximity of training; explore the feasibility of a statewide training coordinator
- ❖ Expand use of alternative methodologies and formats for making training more accessible
- ❖ Develop a focused campaign to increase awareness of opportunities for financing individual professional development

Foster educational partnerships

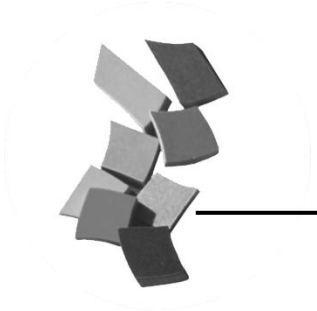
- ❖ Increase outreach to current college students and faculty to enhance the pipeline of ethnically/racially diverse students
- ❖ Increase partnerships with educational institutions, hospitals, and other agencies to establish programs for developing the current CHC workforce
- ❖ Advocate for incentives for diverse students to enter healthcare careers

Promote organizational practices that support diversity

- ❖ Encourage CHC leaders to proactively create settings for addressing diversity issues that emerge in the daily work of the center
- ❖ Reinforce the importance of defining equity to include responsiveness to varied circumstances (i.e., treatment should be equitable but does not necessarily need to be identical).
- ❖ Encourage CHCs to expand their thinking about ways to educate staff about varied cultural traditions
- ❖ Provide consultation on strategies for institutionalizing diversity-oriented practices
- ❖ Continue attention to and expansion of the U.S. Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards -adopted by the U.S. Department of Health and Human Services).

Address payment reform

- ❖ Advocate for coverage of ancillary services, such as interpretation, social services, and/or transportation
- ❖ Advocate for additional funding sources for interpreter service



1. Overview

Our country is grappling with a health care crisis that has rendered quality services out of reach for many people, evidenced by troubling health disparities across ethnic, racial, and socioeconomic lines.[1,2] Economic and social obstacles to medical services are substantial and increasing for many people. One of the critical and intransigent barriers to accessing quality health care involves the mismatch between the ethnic/racial diversity of the U.S. population and that of the health care workforce, especially at professional levels.[3] This report summarizes a survey of community health centers (CHCs) in Massachusetts, plus in-depth interviews with representatives of CHCs from varied Massachusetts regions and ethnic/racial communities served. The report both 1) describes challenges that CHCs face recruiting, retaining, and promoting a workforce that is representative of local ethnic/racial and cultural diversity of the communities they serve and 2) highlights some of the promising organizational practices and policies adopted to enhance the capacity of providers to work effectively across ethnic, racial, cultural, religious, and language differences. Access to quality health care is the focus of current policy debates on a national level, and the results of this study contribute to the ongoing dialogue about establishing more equitable approaches to health care delivery.

Goals of the Healthy Diversity Project

The overall goals of the Healthy Diversity Project are to identify both challenges and best practices for fostering a diverse CHC workforce. Toward these ends, the primary aims of the action-research summarized in this document are:

1. To identify the challenges CHCs face in developing ethnically/racially diverse workforces

2. To better understand the promising organizational policies and practices that CHCs have adopted in their efforts to hire, train, and support a diverse workforce

3. To solicit and summarize recommendations about strategies to further support efforts to integrate ethnically/racially diverse workers into the CHC workforce

4. To distill broader policy implications from the findings and disseminate recommendations.

Background

Despite the federal mandate that health care organizations meet culturally and linguistically appropriate service standards,[4] current health care delivery settings often struggle to work with the broad range of ethnic, cultural, and linguistic groups that are in need of care.[5] To do so clearly requires finely tuned clinical skills and in-depth knowledge of local cultural practices on the part of all medical staff.[6,7,8,9,10] At the same time, the provision of culturally responsive care also requires that attention to ethnic/racial diversity permeates the organization at all levels.[11] In order to develop truly sustainable approaches to culturally responsive care (i.e., that do not depend so heavily upon the skills of individual clinicians who may come and go), health care organizations need to institutionalize a value for cultural diversity throughout all of their employment practices. Such an effort involves employing a diverse workforce at all

levels, supporting the development and promotion of workers who are representative of various cultural and linguistic groups, adopting workplace practices that support cultural understanding and positive relations among diverse workers, and developing creative approaches to recruiting highly qualified medical providers from diverse backgrounds.[12,13]

The importance of diversifying the health care workforce is particularly evident in community-based health centers, which deliver services to the most needy in often multi-cultural, multi-ethnic communities. CHCs are a critical community service utilized by many new immigrant families and thus provide services to groups with widely ranging traditions and beliefs about health and health care. In March of 2009 the Kaiser Commission on Medicaid and the Uninsured released a report detailing the impact of the Massachusetts reform law on community health centers. They found that in 2007, the 34 federally qualified CHCs saw an increase of 51,000 patients over two years earlier. The Massachusetts League of Community Health Centers estimates that CHCs saw 431,005 patients in 2005 and 564,740 in 2009. The challenges are many, and the need to foster an effective workforce that reflects the diversity in the local community is highly salient in these settings.

Historical Context

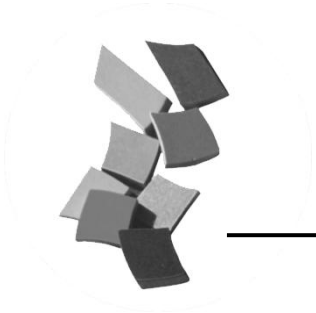
In order to fully appreciate the significance of diversity issues in community health settings, it is useful to consider historical context. The Community Health movement was a grassroots effort that emerged in the 1960s. Activists fought for the idea that quality, comprehensive care should be made available to everyone, without regard to race and socioeconomic status. The movement embodied early recognition that health disparities exist and that life conditions for individuals in poor areas affected their health and their access to quality health care. As such, attention to diversity principles were at the very core of the movement, both with respect to providing health care to diverse peoples, as well as employing a diverse body of workers. The efforts of the Community Health movement paralleled and often overlapped with those of the Civil Rights and the Women's Rights movements. The tenets of equality and access resonated throughout all three movements, which is why people who counted themselves as supporters in one movement often supported the others. The guiding values of the Community Health movement are still alive in today's CHCs, particularly among those individuals who were at the forefront in the formative years – some of whom are still in leadership positions today.[14]

The Current Diversity Challenge

From the beginning, CHC leaders have been committed to hiring and employing from their local communities while providing care for members of these communities. Thus, compared to institutions without such a commitment, they encounter unique challenges inherent in hiring and sustaining a diverse workforce. Yet, it is also CHCs' strong commitment to the community that has supported them to meet those challenges and motivated them to find numerous innovative ways to build and support diverse workforces. As a result, many CHC leaders have gone beyond considering and fostering cultural competencies of their workers at the individual level, to focus on organizational policies that embody cultural competence at a more macro level. As such, CHC leaders are uniquely poised to provide insight into both the particular diversity challenges that community-oriented service organizations face and some best practices for fostering an ethnically/racially diverse workforce. Their experiences can suggest lessons for other community-based health care and human service organizations.

Our goal was to investigate the representational, interactional, and workplace environment factors relevant to hiring, retaining, developing, and supporting a diverse CHC workforce. Representational

issues concern who is employed by the health center and the degree to which the ethnic/racial diversity of the workforce represents or matches the degree of diversity in the patient population they serve. Gender segregation and ethnic segregation are common in organizational settings and they often increase as one moves up the organizational hierarchy,[15,16,17] yet little has been documented about how such dynamics play out in community-based organizations. Interactional challenges are those issues that invariably arise in fostering positive work relations among diverse groups. Across numerous studies, cultural differences among workers have been found to have potentially negative effects on communication, role clarity, and job satisfaction.[18,19] Fortunately, there is also evidence that diversity within a workplace, if managed well, can contribute to increased creativity and overall effectiveness.[20] In health care, it should follow that constructive diversity could enhance organizational communication and problem-solving as well as job satisfaction and employee retention. However, this appears to have been little studied to date in this context. In addition to looking at representation and interpersonal interactions, it is useful to identify specific organizational practices that institutionalize support for a diverse, culturally competent work place environment. Many CHCs have policies that aim to support diverse workers, but the adherence to policies designed to promote diversity within the workplace environment has generally been found to be uneven.[21] Therefore, we were interested in detailing how CHC directors and human resource personnel approach the development and implementation of organizational policies, as well as the ways in which CHCs experience broader level policies (regional, national) affecting their ability to hire, retain, and develop a diverse workforce that can provide relevant care.



2. Study Methodology

The Study Involved the Following:

- Inviting all 52 community health center members of the Massachusetts League of Community Health Centers to participate in a two-part survey
- Conducting follow-up interviews with directors and human resources managers in 10 federally qualified CHC's to learn more about challenges and best practices
- Summarizing findings and sharing with members of the Mass League, public health professionals, policy makers, and academic audiences to distill recommendations

Survey

A survey was sent to all members of the Mass League (n=52). Executive Directors or Human Resource managers were asked to complete a two-part survey. The first part, a demographics form, queried the demographic distribution – in terms of gender and ethnic/racial composition -- of both the employee population and the patient population served. The second part was a questionnaire designed to assess workplace diversity policies and practices, with a focus on both the challenges and strategies related to fostering a diverse workforce. The questionnaire employed a mixed response format, with some questions being closed-ended (participants indicated the best response from a list of possible answers), and some questions being open-ended (participants were asked to respond in their own words). The questionnaire was designed to assess the current approaches to, and challenges around, the following 5 themes: 1) recruitment, selection, and retention, 2) formal organizational policies, 3) diversity of leadership, 4) training and development and 5) more general diversity climate and practices. A copy of the survey is provided in Appendix A.

Interviews

We asked 10 Executive Directors and/or their designated representatives to talk with us further about these same issues. The interviewees, who in most cases also included additional personnel, were invited to expand on three primary themes with specific examples: 1) challenges they face in fostering a diverse workforce; 2) strategies adopted for dealing with these challenges; and 3) barriers to dealing with the challenges more effectively.

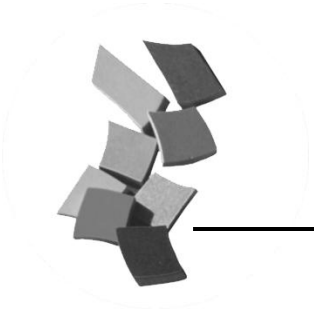
At the conclusion of each interview, we asked interviewees to share any recommendations they might have. We invited suggestions for other CHCs, for the Mass League, and/or changes at a state-level in terms of policy.

Feedback Process

An important element of action research is to ensure that the researchers' interpretation of the data reflects the daily realities of those we seek to understand. To achieve this, it is critical to share findings with constituent groups in the process of distilling recommendations. Toward this end, we shared preliminary findings with selected interviewees and members of the Mass League to solicit their comments and fine-tune our interpretations and recommendations.

The Many Dimensions of Diversity

The focus of this particular study was on ethnic/racial diversity in the workforce, but the word "diversity" includes many dimensions. Some dimensions are more visible than others, some have a greater influence on work conditions, and some are more relevant in particular CHCs than others. Disability status can disproportionately affect an employee's ability to take advantage of development opportunities. Physical accessibility of meetings may be an issue, and if an employee needs to telecommute, s/he may miss out on informal mentoring and networking opportunities. Lesbian, gay, bisexual, and transgender (LGBT) employees add important diversity to the work environment and could benefit from increased sensitivity and validation. Company benefits may exclude their families and seemingly harmless words can serve to marginalize them. For instance, inviting employees and their "spouses" to an organizational event may make LGBT employees feel that their partnership is under-valued. Even though Massachusetts has legalized same-sex marriage, not everyone has or is able to act on this option. In addition, various dimensions of diversity intersect. Even though women in general are very well represented in CHCs, among those centers we surveyed, more positions of leadership are filled by white women than by women of color. White men are disproportionately likely to become leaders. LGBT issues are not visible in many centers, even when ethnic and cultural sensitivity is strong. Furthermore, socioeconomic status (SES) is an important dimension of diversity. Even though it is largely invisible, SES can influence many aspects of interpersonal interactions. Doctors and others in CHCs with advanced degrees need an awareness of the power differentials between them and many other staff, which should in turn help them in providing quality care. To create a welcoming and accepting environment for all, CHCs benefit from reexamining policies and being vigilant about the wide range of dimensions of diversity and the ways in which the dimensions intersect and interact.



3. Survey and Interview Responses

Survey

Participating Centers

Surveys were sent to all 52 community health centers in Massachusetts, which includes 39 centers that are designated as "federally qualified" (FQHC),[a] 5 satellites to these FQHCs, and 8 CHCs that are connected to major hospitals. Some hospital-based CHCs also have multiple sites; however, these are not counted as separate CHCs. Thus, while the Mass League includes 52 CHCs, if multiple hospital-connected sites are counted, the total comes to 56 sites. For aspects of this study related to workplace practices, we were particularly interested in hearing from the FQHCs because they adopt their own personnel policies, whereas the hospital-based centers operate under the umbrella of broader hospital policies and have less autonomy in developing workforce policy. In terms of developing a portrait of CHC workforce characteristics, we included demographic information from the hospital-based centers, as those data help to clarify the populations hired and served by CHCs more widely.

Twenty-five CHCs (29 sites) participated in at least one portion of the survey phase of data collection, consisting of the CHC demographics form and/or the questionnaire, thereby yielding an overall 48% response rate among the 52 CHCs. Of the 44 FQHCs and satellites, 22 main sites and 1 satellite participated in the study (i.e., 52.3%). In addition, 2 of the 8 hospital-based centers participated (i.e., 25%), although it is noteworthy that the 2 participating hospitals have a total of 6 hospital-based sites and submitted separate demographic forms for each (i.e., 6 demographic forms for the 2 hospitals). Nineteen centers responded to both parts of the survey (demographics form *and* questionnaire), 2 centers (3 sites) provided only answers to the questionnaire, and 4 centers (7 sites) completed only the demographics form. See Table 1 for overview of response rates.

In sum, we received 26 responses to the questions about demographics (20 from FQHCs and 6 from sites connected to 2 different major hospitals). We received 22 responses to the questionnaire portion of the survey (18 from FQHCs, 1 from a FQHC satellite, 3 from hospital-based CHCs – 2 of which are connected to the same hospital). Questionnaire results summarized in this report only include responses from the FQHCs and satellites (n=19) because those are the centers that are able to adopt their own independent staff policies and practices.

In terms of the geographical dispersion of the participating centers, 15 of the centers (60% of the study participants) are located in the greater Boston area, the area with the largest concentration of CHCs in the state (29 of 52). We received responses from 2 CHCs in northeastern MA and 7 in central/southern MA. While we received only one response from a CHC located in the western part of the state, this is also an area with a relatively small concentration of CHCs (i.e., a total of 8 of the 52 Massachusetts CHCs are located in this area).

[a] FQHCs are community-based organizations that provide comprehensive primary care and preventive care services to persons of all ages, regardless of their ability to pay. The FQHC is a federal designation from the Bureau of Primary health Care (BPHC) and the Center for Medicare and Medicaid Services (CMS) that is assigned to non-profit or public health care organizations that serve uninsured or medically underserved populations.

Table 1: Survey Responses*

Community Health Centers	N	Responses to Survey Components		Total Responses	Response Rate
		Q'aire	Demographics		
Federally-qualified centers & satellites	44	19 centers	20 centers	23 centers	52.3%
Hospital-based centers	8	2 centers (3 sites)	2 centers (6 sites)	2 centers (6 sites)	25.0%
Total	52	21 centers (22 sites)	22 centers (26 sites)	25 centers (29 sites)	48.0%

**Note*: While 25 total CHCs participated in at least one part of this survey, some CHCs had multiple sites. As such, the total number of sites that participated was 29.

Center Demographics

The data allow us to draw a portrait of CHC demographics from several angles:[b]

- *Workforce Demographics*: Who works in Massachusetts CHCs?
- *Patient Demographics*: Whom do these centers serve?
- *Patient-Community Match*: To what extent does the patient population reflect the ethnic/racial diversity within the community?
- *Workforce-Community Match*: To what extent does the CHC staff reflect the ethnic/racial diversity within the community?
- *Workforce-Patient Match*: To what extent does the CHC staff reflect the primary ethnic/racial populations served?

Workforce Demographics (n=25). In order to get a portrait of the demographic make-up of the CHCs, we computed the average percentages[c] across gender and ethnic/racial categories. On average, there are more female employees working in CHCs than men. The average percentage of women across centers is 78.9%; the average percentage of men is 20.9%. When gender was analyzed by staffing category, we found that women tend to occupy higher level positions more than men. For the purposes of this study, executive, managerial and professional clinical provider categories were considered higher-level positions. Women, on average, occupy 72.9% of leadership positions; men occupy 27.1%. However, looking at the distribution within gender, men were on average 6% more likely to hold higher level positions than their average across staffing categories, as compared to women who were 6% less likely to hold higher level positions than their average across staffing category. In other words, if you are a man working at a CHC, you are more likely to be in a higher level position even though the workforce is dominated by women (Figure 1).

[b] Not all of the 26 demographics forms included complete data, which meant that we had to exclude some centers in some analyses. As such, our Ns differ depending on the analysis; we indicate how many sites were included for each analysis.

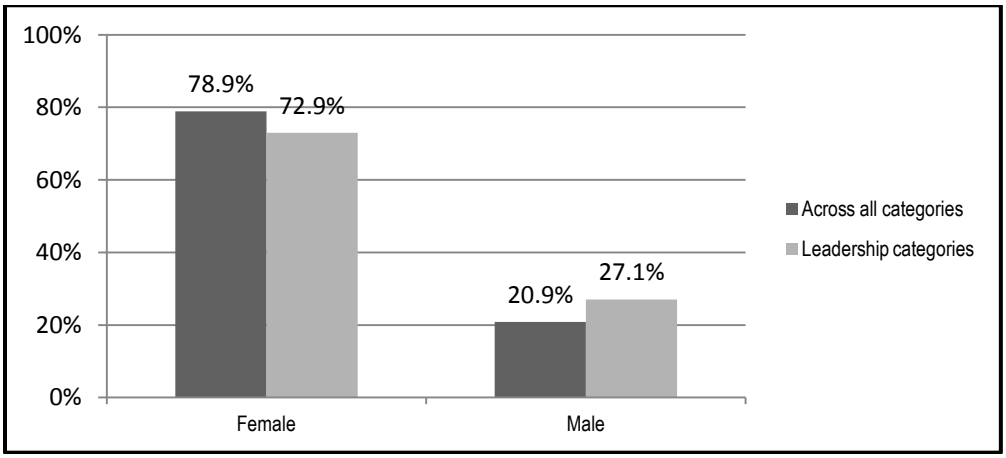
[c] Given the variance in the number of total employees working at any one CHC, we report average percentages across centers rather than total percentages based on raw numbers. That is, for each demographic variable, we computed a percentage for each center (for example, the percentage of women and men working at an individual CHC). We then averaged these percentages across centers. This method takes into account the vastly different sizes of individual organizations, such that each CHC's demographics is equally weighted in the average provided. Therefore, the percentages reported do not (and should not necessarily) add up to 100.

Table 2: Center Gender Demographics*

	Female	Male
Workforce Demographics	78.9%	20.9%
Patient Demographics	56.0%	44.0.5%

**Note:* Average percentages across all centers.

Figure 1: Workforce Gender Composition Across All Staffing Categories & Leadership Positions (n=25)



White/non-Hispanic employees are the most prevalent ethnic/racial group, with an average representation of 47.2%, followed by Hispanics/Latinos (20.4%), black/non-Hispanics (14.9%), and Asian or Asian-American (10.5%). CHCs reported low percentages of staff categorized as Native American and Alaska Native (.28%), Native Hawaiian and other Pacific Islanders (.03%), two or more races (.99%), other race (.67%), and unknown (5.07%).

Table 3: Center Ethnic/Racial Demographics*

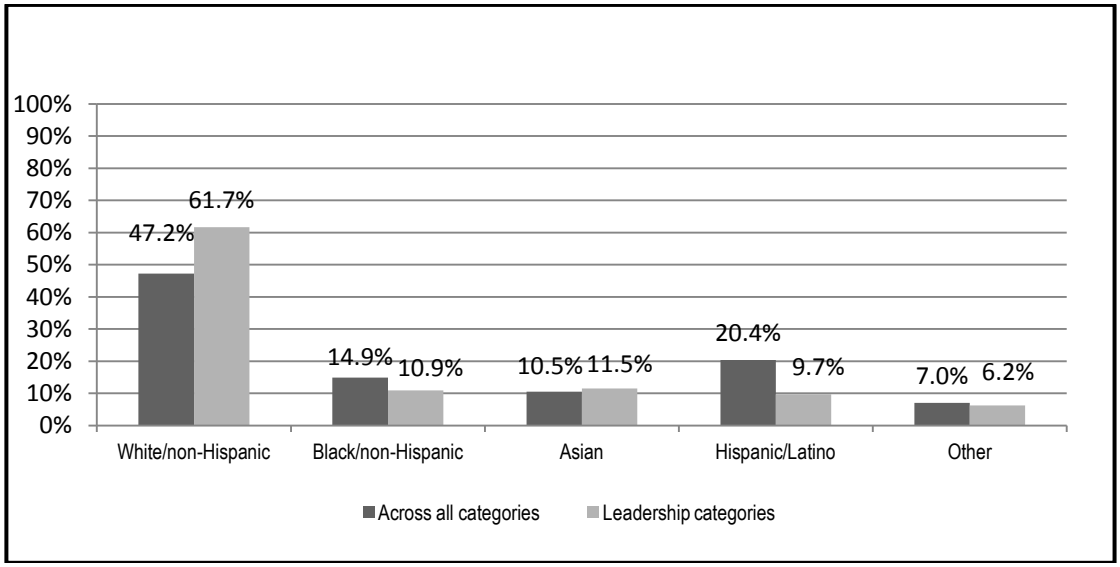
	White/ Non-Hispanic	Hispanic/ Latino	Black/ Non-Hispanic	Asian	Other
Workforce Demographics	47.2%	20.4%	14.9%	10.5%	7.0%
Patient Demographics	37.2%	27.9%	15.9%	8.7%	10.3%

**Note:* Average percentages across all centers. "Other" includes ethnic/racial categories with < 1% and unknown.

Within the leadership positions, white/non-Hispanic employees are even more disproportionately represented. Across centers, an average of 61.67% of the leadership is white. Asian employees, despite being the least prevalent of the four major ethnic/racial groups in the general workforce, are the second

most prevalent ethnic/racial group in leadership positions, and occupy an average of 11.48% of such positions. Black/non-Hispanic leaders are the third most prevalent at 10.93%, followed by Hispanic/Latinos employees occupying 9.71% of leadership categories, notably this is less than half of their representation across all staffing categories (Figure 2).

Figure 2: Workforce Race Composition Across Staffing Categories & Leadership Positions (n=25)



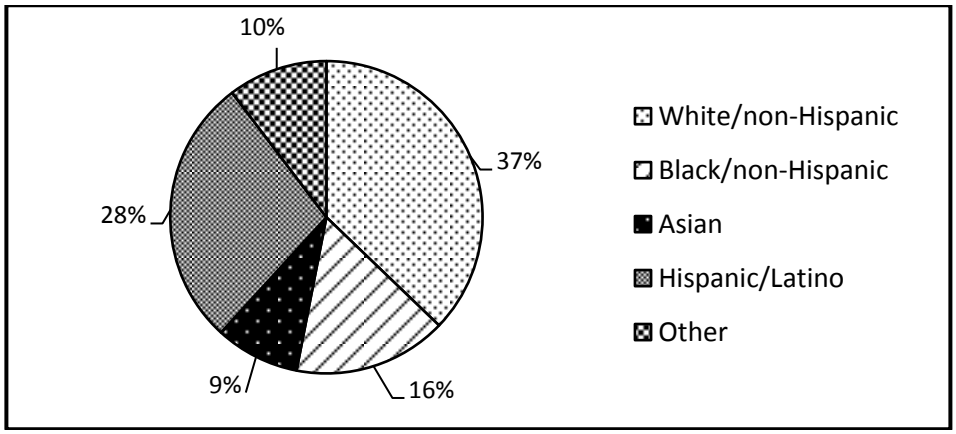
In sum, ascending the organizational hierarchy, the workforce is less and less ethnically/racially diverse. In considering why this pattern emerges, it is useful to consider the socio-historical origins and growth of the CHC movement. The movement, emerging only 50 years ago, was spearheaded by predominantly white/non-Hispanic individuals. Many of the leaders and activists present at the beginning of the movement have only recently left, or still remain in, CHC leadership positions. Arguably, the pipeline for this particular setting has only been in the making for a short while, and thus it is not surprising that the current leadership would reflect a similar lack of diversity. However, it is also the case that decreasing diversity as one goes up an organizational ladder is a perennial and pervasive issue faced by many organizations across multiple sectors, one for which history is often evoked as an excuse.[22] Time will tell to what extent the pipeline argument alone can account for the lack of diversity in CHC leadership positions, or conversely whether internal developments in the past 50 years will support the emergence of a new cadre of leadership in the near future.

Patient demographics (n=23). In order to develop a demographic portrait of the CHC patient population, we computed the average percentages for gender and ethnic/racial categories across centers. Our results indicate that, on average, 56.0% of patients served by CHCs in the study were female and 44.0% were male (averages are across all centers).

The average ethnic/racial composition of the patient population across participating centers was as follows: white/non-Hispanic (37.2%), Hispanic/Latino (27.9%), black/non-Hispanic (15.9%), Asian (8.7%) and other (10.3%). Tables 2 & 3 provide a summary of the gender and ethnic/racial breakdown of workforce and patient demographics side by side. However, given that the distribution of ethnic/racial groups varies dramatically across the state, an average of the ethnic/racial breakdown of the patient population across participating centers does not fully capture the heterogeneity across all Massachusetts

centers on this dimension.[d] One center may predominantly serve white/non-Hispanic clients, another may serve predominately Asian clients, whereas another may serve multiple populations in roughly equal proportions. Thus average percentages may obscure the demographic portrait of any individual center (Figure 3).

Figure 3: Patient Ethnic/Racial Composition Across Centers (n=23)



While confidentiality precludes us from reporting patient demographics (or workforce demographics) center by center, there are arguably three more important determinations that can readily be addressed by the compiled statistics: To what extent is the population served by individual CHCs representative of the population of the community in which it is located? Does the population of the workforce reflect the community in which it is located? Finally, and perhaps most importantly, does the workforce of individual CHCs match the patient demographics?

Match

To provide culturally competent care, it is important that patients are greeted and cared for by employees who can speak their language and recognize the differential values (particularly those relevant to health) of their particular ethnic/racial or cultural group. The notion of "match" is different from the notion of "diversity." For example, a CHC that exists in a community with predominately one ethnic/racial group and hires from that community may have excellent *match*, but if only one ethnic/racial group is represented both in the workforce and the community, it is not diverse. Attention to and understanding of both concepts is critical for the experience of both patients and staff.

We defined and calculated three sets of *match* variables: 1) between patients and the community in which the CHC is located; 2) between the CHC workforce and the local community; and 3) between the CHC workforce and patients served. A similar approach was used to assess each of these three *match* constructs. For patient-community *match*, we compared the patient demographics reported by the centers to the most recent complete census data (2000).[e] For Boston-based CHCs, we searched census data by zip code to assess the ethnic/racial composition of the urban community served. For CHCs

[d] Furthermore, note that many of the CHCs that chose to participate in our study are located in the Greater Boston area. We received relatively few demographics forms from western Massachusetts and Cape Cod, which inevitably affects any ability to generalize from our summary of demographic data.

[e] The 2010 census data has not yet been released in the format required in order to complete this analysis; specifically, the degree of specificity of our racial categories by zip code is not yet available.

outside of Boston, we looked at the census data for the city/ies in which the center is located. For CHCs that have several sites but provided only one demographic form, we looked at census data for each site and then averaged them to create 1 set of data corresponding to that CHC. For the other two *match* calculations, we relied on data provided by participating CHCs.

To quantify the degree of *match* we identified the top two demographics groups for each component of the particular *match* variable of interest and determined the degree of correspondence between them, in the following four categories:

- an *excellent match* (the top 2 demographic groups for each population, i.e., the community, patient or workforce, were the same as the top 2 demographic groups for the comparison population)
- a *match* (the top 2 groups were identical, but not ranked in the same order)
- a *match of one* (agreement on only one of the top demographics groups)
- *no match* (no agreement between top 2 demographic groups for the populations compared)

Patient-Community Match (n=23)*.* The first critical determination was whether the patient population served by each individual CHC is representative of the local community in which the center is located. This serves as a foundation for framing the potential relationship between the patient population and the workforce, with implications for cultural competence (as discussed above). This information is also important to the extent that serving the community is a critical goal of the community health movement. Of the 23 CHCs who completed demographic data for patients, 7 centers had *excellent match*, 6 centers had *a match*, and 9 centers had a *match of one* of the two main groups, 1 center was categorized as *no match*.

These results suggest that most CHCs are indeed providers that are utilized by their surrounding communities in a manner that reflects the racial/ethnic diversity within those communities. This diversity in the patient population also underscores *both* the importance of employing a workforce that matches that local diversity *and* the potential for doing so by hiring from within the local community.

Workforce-Community Match (n=25). The extent to which the workforce of each CHC matches the community in which it is located is important for several reasons. First and foremost, one of the stated goals of CHCs is to employ individuals from the local community. Data from this survey allowed us to assess the degree to which CHCs have been successful in doing so. Moreover, the extent to which the diversity of the workforce mirrors the diversity in the local community may have implications for how well the CHC can serve the community.[23] Potential patients may be more apt to utilize a local CHC if they believe they will find providers who will be able to address their health needs in a culturally responsive manner. Of the 25 CHCs that had complete demographic data for workforce, 14 centers had *excellent match*, 6 centers had *a match*, and 5 centers had a *match of one*. None of the centers had *no match*.

Workforce-Patient Match (n=23). Our final *match* analysis involved determining the degree to which the demographic diversity of an individual CHC workforce matches the demographic diversity of its patients. As many experts have indicated, a critical step towards providing culturally responsive health care is to employ a workforce that reflects the linguistic and cultural diversity within the patient population served.[24] Twelve centers had *excellent match*, 3 centers had *a match*, and 8 centers had a *match of one*.

Figure 4a: Patient-Community Demographic *Match* (n=23)

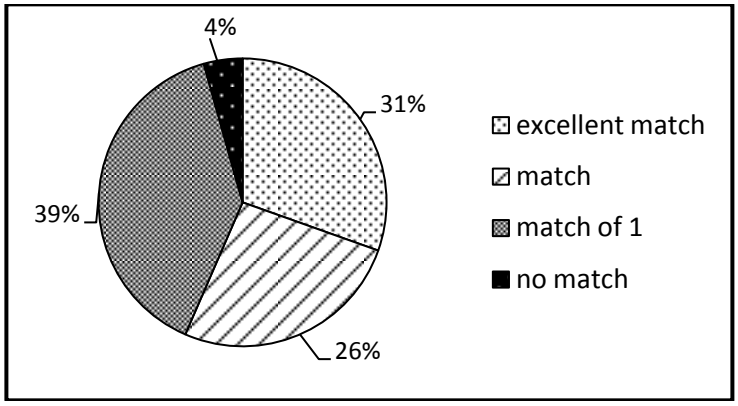


Figure 4b: Workforce-Community Demographic *Match* (n=25)

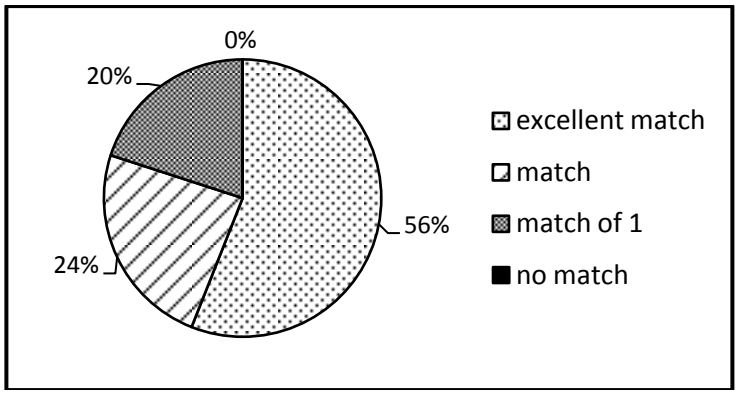
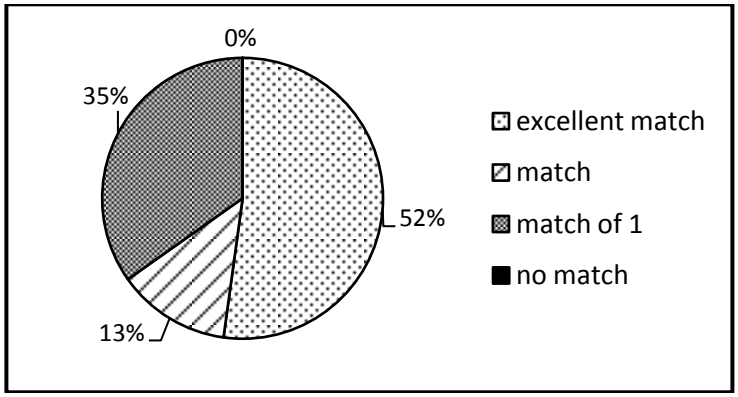


Figure 4c: Workforce-Patient Demographic *Match* (n=23)



In sum, while the concept of *match* is an important one, it is also necessary to note that our 3 *match* variables represent a snapshot of the organizations at a single point in time. In many low-income communities, the ethnic, racial, and cultural makeup can change quickly as new immigrant or refugee groups move into an area, and with those changes, patient populations will change. CHCs work to ensure that they can meet the linguistic and cultural health needs of new populations and part of this

inevitably includes reaching out and hiring from the new groups. However, staffing to match unpredictable and shifting demographics among patients can put a strain on centers – both in terms of requiring funding to hire new employees and in terms of accommodating new languages and cultural traditions in the structure of health care delivery. This dynamic illustrates how complex it really is to be constantly "culturally competent" when the cultures in the community being served are numerous and fluid.

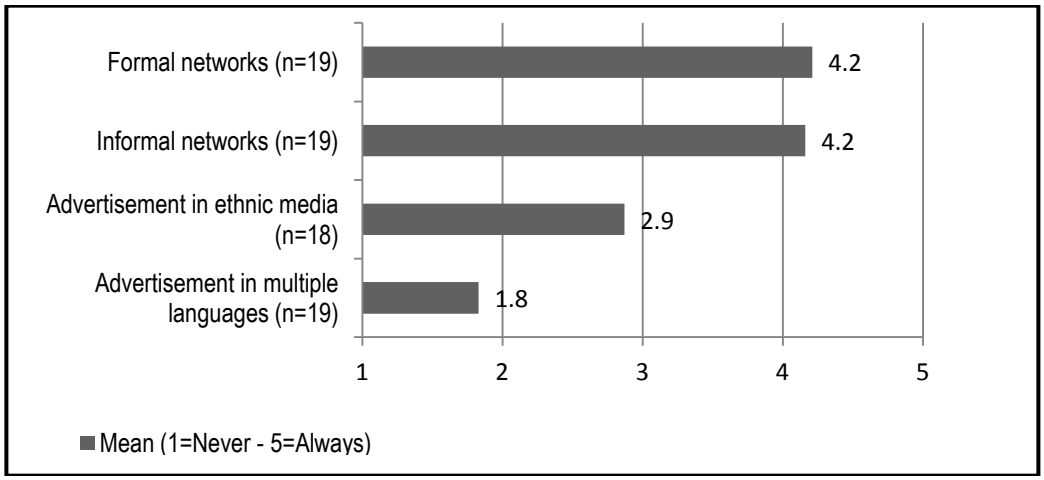
Furthermore, we recognize that particular CHCs may attract particular groups, regardless of the availability of a CHC that is closer in proximity. A center that has a reputation with a particular cultural or ethnic group may attract patients from other areas of the state. Also, demographics are constantly evolving and changing on census forms, impeding the ability to determine *match* over an extended period of time, or even from one census to another. While both of these issues represent the challenges of determining *match*, it is an important concept nonetheless and deserving of examination.

Questionnaire Responses

The questionnaire responses were analyzed to summarize the key issues, barriers, and strategies shared by respondents. (Given the small number of CHCs, formal statistical correlations and comparisons would be inappropriate.) We were particularly interested in identifying types of challenges and best practices that seem to have emerged for specific ethnic/racial groups of workers. For example, a center that serves primarily Southeast Asian and African immigrant groups is likely to confront different diversity dynamics among workers than a CHC in a community that has large Puerto Rican and Dominican populations.

Recruitment. CHC representatives were asked to indicate the extent to which they employed various methods in recruiting a diverse workforce, as rated on a 5-point scale (1=Never; 5=Always). Interestingly, the most common recruiting strategies were consistent across job type. Formal and informal networks were cited as the most frequently used methods for recruiting ethnic/racial minorities, while advertising in ethnic media and in multiple languages were cited as used less frequently (Figure 5).

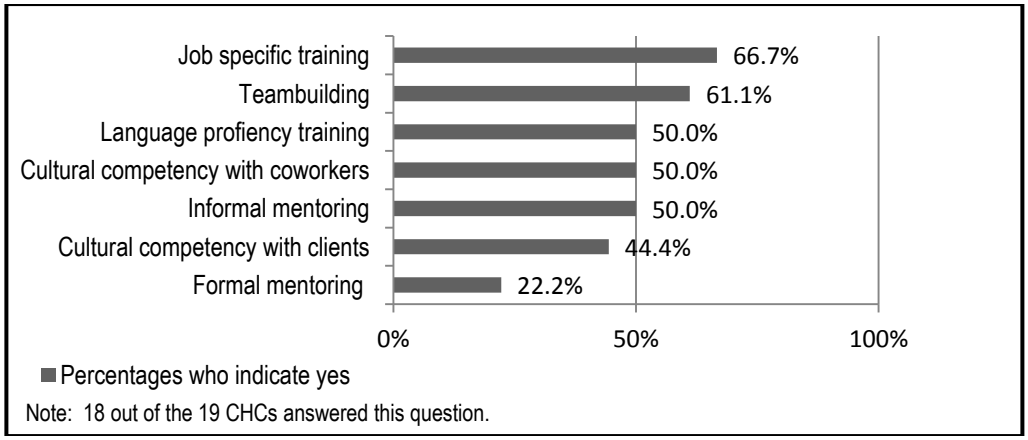
Figure 5: Recruitment Strategies Across Staff Categories



Training. A variety of training opportunities are offered for employees within the participating CHCs. The four topics addressed most often include job-specific skills training (66.7%), team-building (61.1%),

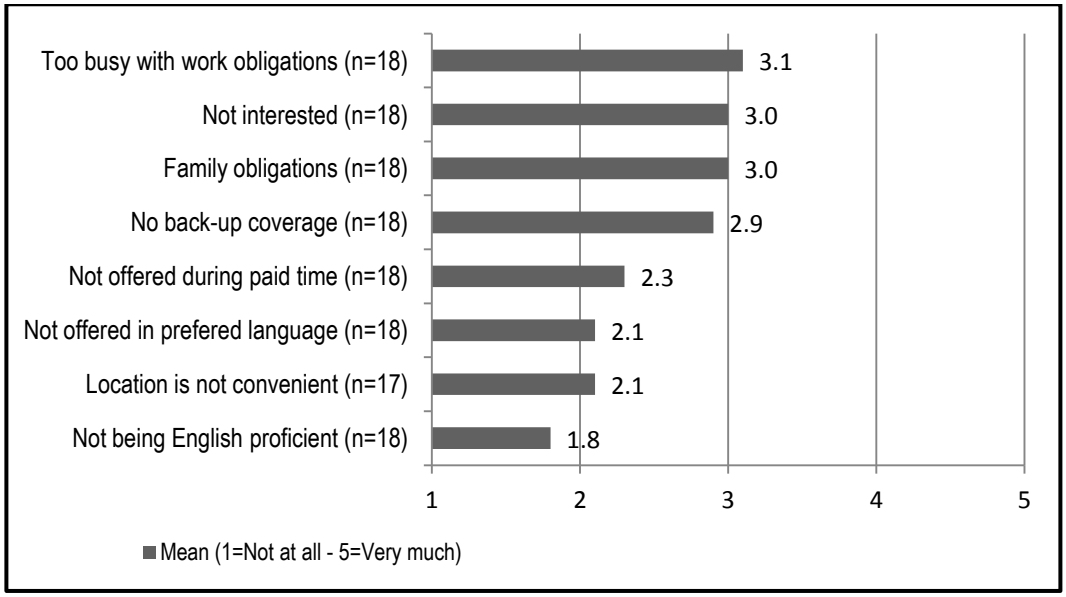
language proficiency (50%), and cultural competency with coworkers (50%). While 50% of CHCs reported an informal mentoring program in their center, only 22.2% reported a formal mentoring program (Figure 6).

Figure 6: Training Provided



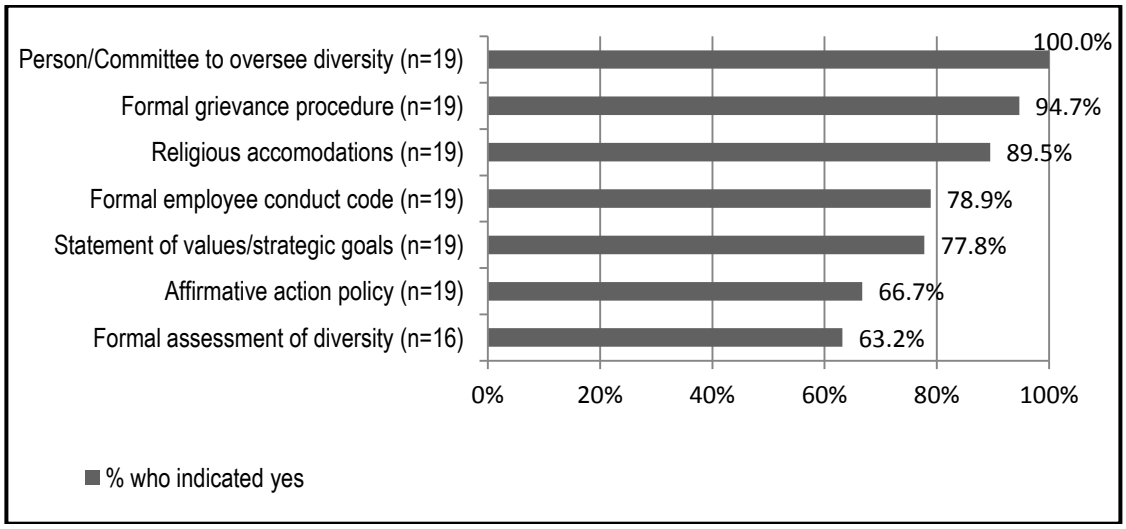
The CHC representatives also identified barriers that can prevent staff from taking advantage of these supports. CHCs rated potential barriers on a 5 point-scale (1=not at all; 5=a great extent). The three top barriers were time constraints, including staff too busy with work obligations (mean=3.13); perceived lack of staff interest (*mean*=3.00); and no back-up coverage (*mean*=3.00) (Figure 7). Unfortunately, we did not have independent information from staff members regarding their own training interests and perceptions of access and opportunity; a future expansion of this study to include surveying staff could provide useful data to triangulate with these and other findings based solely on administrators' perceptions.

Figure 7: Barriers to Accessing Training



Organizational Policies & Practices. A number of organizational policies and procedures to foster a climate that respects diversity were cited. All of the centers (100%) reported having a specific person or committee whose job it is to oversee diversity-related goals and activities. In addition, 94.7% reported having a formal grievance procedure. However, only 66.7% indicated that they had affirmative action policies, and 63.2% of centers indicated that they formally assessed organizational performance in achieving diversity staffing goals (Figure 8).

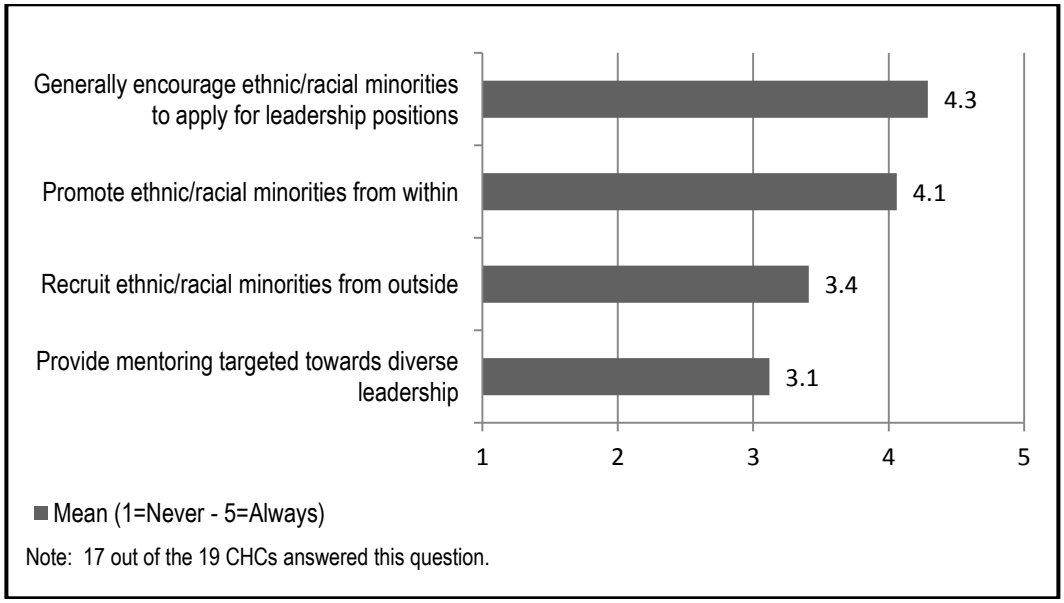
Figure 8: Organizational Policies & Practices



Diverse Leadership. CHC representatives were asked to rate the extent to which they considered ethnic/racial diversification of their leadership to be a strategic priority and the extent to which they were satisfied with the ethnic/racial diversity of their current CHC leadership (on a 5-point scale with 1=not at all satisfied, and 5=very much satisfied). Overall, the majority of the CHC administrators believed that diversification of the leadership was an organizational priority "to a great extent" (*mean*=4.29). The majority of CHCs also reported being somewhat to very much satisfied with the ethnic/racial diversity among leaders at their organizations. CHCs indicated being most satisfied with diversity at the professional level (*mean*=4.24), followed by the managerial level (*mean*=3.88) and the executive level (*mean*=3.82).

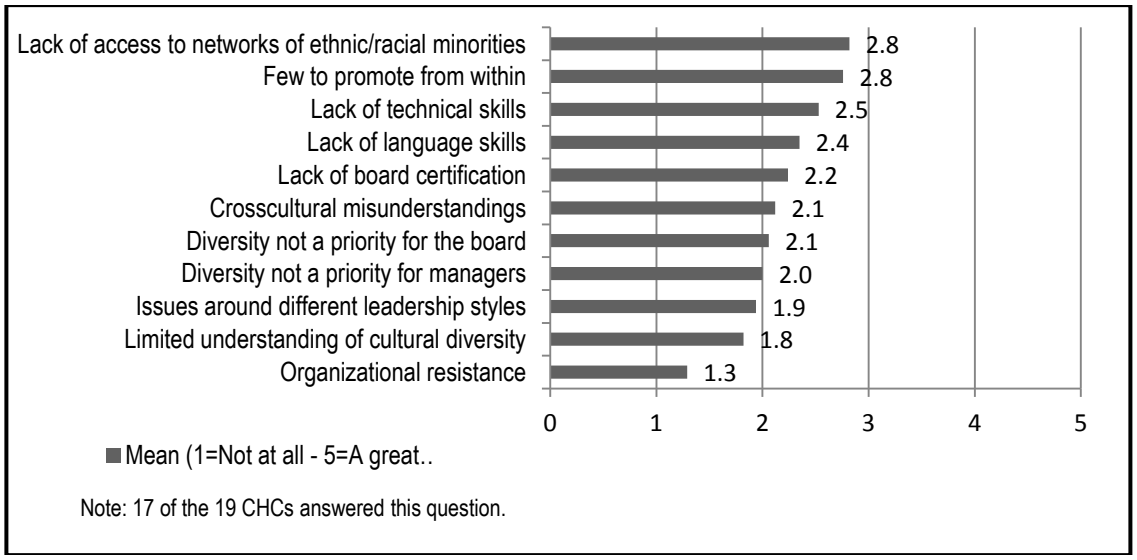
CHC representatives identified strategies adopted to foster diverse leadership and rated the frequency with which they utilize these strategies. The two strategies utilized most often were to actively encourage ethnic/racial minorities to apply for leadership positions, both by direct staff referrals and general word of mouth (*mean*=4.29), and to promote from within the organization (*mean*=4.06) (Figure 9).

Figure 9: Strategies to Foster Diverse Leadership



The three barriers to increased diversity in leadership most often endorsed were: 1) lack of access to minorities from outside the organization (*mean*=2.82); 2) too few candidates to promote from within (*mean*=2.76); and 3) lack of technical skills among diverse candidates (*mean*=2.53). However, none of the barriers listed on the survey were rated as particularly troublesome (*means* ranged from 1.29 to 2.82) (Figure 10). Other potential barriers were explored in the interviews (see "Cross-Cutting Themes," below).

Figure 10: Barriers to Diverse Leadership



Interestingly, some of the primary barriers cited in diversifying leadership, in particular the pipeline issues, are mirrored in the strategies used to overcome these obstacles. In other words, although

promising, active outreach to ethnic/racial minority candidates and efforts to promote from within are not without significant challenges.

Questionnaire Summary. It is clear from the questionnaire responses that CHC administrators value diversity in their workforce. All respondents reported having a person or committee that oversees diversity initiatives and having invested time and energy into ensuring representation of ethnic/racial minorities within all levels. Furthermore, the study participants acknowledged that they need to – and can – continue their efforts to address challenges to recruiting and retaining a diverse workforce as well as to create more opportunities for fostering an inclusive work environment.

Interviews

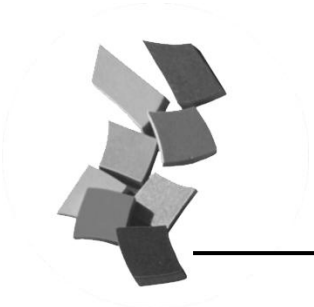
To complement the information gathered through the two-part survey (demographic grids and the questionnaires), we conducted interviews with representatives of 10 federally qualified CHCs.[f] We asked centers to identify a contact person who was well informed about diversity issues within the center. In most cases, we interviewed the Executive Director, often along with the HR Manager and another staff person tasked with implementing specific diversity-related efforts. In other centers, we met only with the HR Manager and/or the person most directly responsible for hiring and training staff, again often alongside someone directly involved with in-house diversity initiatives.

The interviews focused on three questions:

1) What do you see as the main challenges that you face in recruiting, hiring, training, and retaining a diverse workforce?
2) What are some of the ways that you have approached these challenges? What works? What hasn't worked as well?
3) What are some challenges or dilemmas that you feel still need to be addressed, and what support would help you in approaching these challenges?

In the following section entitled "cross-cutting themes," we summarize issues that were raised *across* the interviews and augment the discussion with insights from the questionnaires.

[f] We would like to acknowledge the students in the Community Social Psychology program at the University of Massachusetts Lowell, who helped with interviewing key personnel at the community health centers as a part of their Workplace Diversity course in the fall of 2010. They are Molly Berry, Jonathan Bulger, Kaitlyn Corcoran, Faythe Cote, Jennifer Gevry, Samantha Jacobs, Megan Lewis, Michael Lucido, Michaela McKenna, Margaret Quinlan, Charya Uong, & James Warren.



4. Cross-Cutting Themes

In general, factors at multiple levels influence an organization's effectiveness in recruiting, retaining, and developing a diverse workforce. For community health centers, these factors directly impact the provision of culturally relevant care. Adopting a framework from past research on workplace diversity, the challenges – and opportunities – can be seen as falling into three broad categories: 1) representational, 2) interactional, and 3) workplace environment. [25,26]

Challenges

Representational Challenges – Focus on Diverse Staff Demographics

The diversification of staff is essential for establishing the cultural responsiveness of health care programs, and the challenges around recruitment, retention, and development are part of the representational challenge. However, hiring, developing, and retaining both medical providers and support staff who reflect and understand the diversity within the community is more challenging than it might seem. There are many nuances to navigate, from understanding the role local cultural institutions play in the lives of community members CHCs are trying to recruit, to understanding the role acculturation stress might have on retention.

Recruitment Issues: Challenges in recruiting a diverse workforce were relatively easy for CHC representatives to identify, since the seemingly simple act of getting the right people in the door can be difficult for all levels and all job types. Recruitment issues range from challenges in attracting qualified bicultural and bilingual employees to difficulty competing with hospital salaries.

- <u>Limited opportunity for community members to develop primary job skills</u>
  While study participants did cite hiring from the community as a high priority, they described how they often find it difficult to identify local applicants with the requisite skills. Participants from several centers observed that within low income areas, many community members may have had only limited opportunities to gain skill sets critical to their jobs. Basic job skills may need to be developed, such as professional etiquette and interpersonal skills that are essential for serving community members from wide ranging cultural and linguistic backgrounds. Additionally, many jobs at CHCs require employees to have strong math skills, particularly at the medical assistant and nursing levels. Thus, CHC administrators are often challenged to help entry-level employees develop primary job skills, while also helping them develop necessary technical competencies.

  "People feel more comfortable when they have folks of their own culture taking care of them. But it [also] comes down to skill set – finding people from diverse cultures that have the skill sets we need. We need some very technical skill sets. It's challenging."

- <u>Difficulty identifying qualified culturally diverse applicants for medical and leadership positions</u>
  Several respondents discussed the challenges around recruiting diverse qualified applicants for higher level positions within their CHC. In particular, many centers expressed difficulty in finding employees who are both bilingual *and* bicultural. They emphasized that it is not enough to speak another language, but that truly effective communication between staff and patients happens

when employees also have a strong understanding of patients' particular cultures and cultural views on health and health care. Many center representatives noted that a challenge of particular concern is that there simply are not enough diverse applicants graduating from, or indeed heading into, health care fields. There is a need for a stronger educational pipeline to encourage professional development for bilingual and bicultural health care providers.

- Competition when recruiting for diversity
  There exists a great need for qualified bicultural and bilingual health care providers across many types of medical settings, not just within CHCs. Thus, competition is strong for these individuals. Hospitals tend to offer higher wages than many CHCs and thus have an advantage hiring and retaining medical providers with these important skills. Additionally, several CHC administrators expressed frustration that employees whose professional development they fostered have been hired away by hospitals that could attract them with higher salaries.

  "One of the biggest barriers is we pay very well for health centers, but we usually don't compete with the downtown hospitals. We can't."

  "You don't keep [bilingual, bicultural staff] as much as you sometimes want…Frankly, there's a really big hospital system here and they need to hire people who are bilingual/bicultural, and they pay more!"

- Limited recruitment budgets
  There are clearly medically qualified individuals from diverse backgrounds who are very committed to working in community-based setting and are not entirely motivated by higher pay. However, many CHC administrators feel hampered by limited recruitment budgets from identifying and reaching out to those candidates.

- Where there is more diversity, it is harder to match
  A goal of most CHCs is to recruit employees who reflect the specific populations that they serve, not just to hire a culturally and linguistically diverse workforce. The challenge of achieving such a *match* is intensified in communities where there is a wide range of ethnic/racial groups – and where the ethnic/racial make-up of the community changes rapidly. For example, it is more workable to staff to achieve workforce-patient *match* in a center that primarily provides services for Asians (even though there is tremendous diversity among various Asian populations) than to achieve such a *match* in centers that serve several Asian and Southeast Asian groups, African immigrants from varied countries, and Latinos/as from different regions.

Staff Development Issues: Many CHC leaders make a strong commitment to staff development. Nonetheless, there are challenges on this front, rooted both in internal organizational issues and in workers' lives outside the centers. For example, limited funding and time shape what training can and cannot be offered, while staff with limited social support outside of work may be constrained from taking advantage of critical training sessions or meetings that fall outside daytime hours.

- Limited CHC resources to develop existing workers
  Diverse entry-level workers have wide ranging needs – from limited work experience to lack of U.S. credentials to limited English-language skills. When coupled with small training budgets, this forces CHC administrators to offer only the highest priority or most urgent trainings, leading to gaps in professional development offerings. Additionally, when trainings are provided, there is often limited time to solicit important feedback from participants, which can make effectiveness

difficult to gauge. While there are often good trainings offered by external groups, many are located in Boston. For CHCs outside of the city, taking advantage of these opportunities requires additional time and financial resources to cover travel.

- Stressors in lives of local community workforce
  Communities surrounding CHCs are often low-income, and, as such, many residents experience multiple life stressors. The numerous stresses extend beyond direct economic circumstances. For example, new immigrants, who have often left family and friends behind in their home country, may have limited support systems, feel isolated, and/or lack access to informal sources of childcare, elder care, or transportation. The lack of such supports can not only make day-to-day work more difficult, but it particularly limits their ability to invest additional time to take advantage of trainings that might enable them to qualify for advancement.

> *"There are not only a lot of our patients who live in poverty, but a lot of our staff [come from]…the world of poverty."*

- Scheduling and logistical barriers facing workers seeking further formal education
  Workers motivated to advance in their careers often experience scheduling and logistical barriers to seeking further formal education. Many CHC representatives believe that the best way to ensure that the diversity they have within the ranks of entry level staff permeates the full organizational hierarchy is to help current workers attain further formal education. For example, several CHC administrators could identify medical assistants who would like to advance to the position of nurse. However, it can be difficult to find formal education programs that allow people to continue working full-time while obtaining their degrees. Employees who may need to leave work early to attend class may not be able to find coverage in the CHC. Furthermore, many CHC employees do not have financial flexibility to work part-time while attending school.

Interactional Challenges – Focus on Work Relations

Fostering positive work relations can be particularly challenging in work settings with diverse staff. Managing a diverse staff requires attention to interactional issues at many levels, from informal interpersonal interactions, to internal team dynamics, to cross team communication and coordination. Working relationships among co-workers who do not necessarily share similar interpersonal expectations or ways of communicating are not typically easy – and workplace relations within CHCs are no different.

- Interpersonal misunderstandings at work based in cultural differences
  One common challenge within a diverse workforce is the possibility for conflicting work and interpersonal styles. What may seem like common interpersonal exchanges to one cultural group may be offensive, or even threatening, to another. Seemingly "minor" issues like volume and tone of voice can lead to misunderstandings. Accepted degree of directness and physical distance vary by culture. For example, a Russian doctor who speaks loudly and briskly to her Asian-born assistant may mean only to be efficient, but the assistant may worry that the tone conveys a message that she/he has done something wrong. Such cultural differences can easily lead to tension and hurt feelings, but even more importantly, they can get in the way of effective communication of important health information.

- Culturally varied health practices among staff
  In addition to cultural differences in interpersonal style, what may seem like standard health care practices to one ethnic group may be disrespectful and off-limits to another. Many groups have culturally grounded values about issues of health and health care. Some such issues are at the core of effective health practice. For instance, when treating Cambodian patients, it is critical that a practitioner understands the cultural importance of age and how to behave when the practitioner is younger than the patient. Differences related to cultural health practices can also be of a more pragmatic nature. For example, one health center director discovered that dentists trained in some other countries count teeth in a different manner than dentists trained in the United States. So tooth number 4 may signify a different tooth to dentists and dental assistants from varied countries.

- Interpersonal misunderstandings related to language issues
  In many CHCs, tensions emerge around languages spoken in the workplace. This is another issue that has both interpersonal and practical implications. Interpersonal issues emerge, for instance, when some staff speak a language on the job that is not understood by all. This scenario can make coworkers feel uncomfortable and lead to inaccurate assumptions about the content of conversations. On the more practical front, scheduling existing multilingual staff to cover all languages needed on all shifts is near impossible, particularly in centers with extremely linguistically diverse patient populations. While telephone interpretation services are improving, they cost additional money and cannot take into consideration important non-verbal aspects of communication or cultural variations within a linguistic group.

- Relationships outside of work complicating work relationships
  The commitment of CHCs to hire locally can have interesting, and sometimes troubling, side effects when employees have close relationships with one another outside of work. Informal community networks are invaluable when recruiting a representative workforce, and thus it is not uncommon to find multiple family members and very close friends working side by side at the same center. Interviewees told numerous stories about awkward dilemmas: what's the best way to approach a situation where a mother and daughter are both being considered for promotion and only one will get it, how will transferring an employee to a different location affect their siblings, or what are the reverberating effects when an employee needs to be disciplined or let go while multiple generations of their family continue to work at the center. More troubling are the moments when, even if done inadvertently, employees access and share confidential health information with friends or family.

  "We try to be careful; family members cannot supervise other family members, it just doesn't work out…it is a challenge."

Workplace Environment Challenges – Focus on Institutionalization of Values for Diversity

Workplace environment challenges include issues around both the formal policies that embody values for diversity and the informally accepted "ways of doing things around here." Health care settings have complex structures that present particular challenges in terms of establishing and communicating shared organizational values about culturally responsive and appropriate health care delivery. Some of the work environment challenges can be understood as tensions between different sets of priorities.

- Staff practices that support diversity sometimes seem in conflict with attending to immediate needs
  We found that all of the CHC leaders interviewed were clear about the importance of hiring for diversity. However, many also described a tension between valuing diversity and the reality of health care business. There is an urgency built into the business of health care delivery, and the need to move quickly can come into conflict with the time and deliberateness required to staff for diversity. For example, nursing positions cannot safely remain unfilled without potentially compromising service delivery. Reaching beyond the immediately accessible pool of white women in their mid 20's, however, can take time. People doing the hiring in CHCs may want to do the active outreach needed to identify strong diverse candidates, but the fast-paced environment of a CHC presses for filling a position quickly, making it stressful to take the needed time.

- Definitions of "fair" or "doing good" not always actively supportive of diverse staff
  There are widely varying definitions of what it means to be "fair" or to "do good." The entire CHC movement is grounded in values for fair and equitable access to quality health care. However, we found that some centers feel a tension between an emphasis on fairness or "doing good" and focused efforts to support a diverse staff. Fostering a diverse workforce requires more than having good values and meaning well; it requires a dedicated approach that incorporates close attention to the ways in which staff from varied cultures and circumstances experience the world. This dilemma expresses itself in at least two types of challenges: one emerging from rigid applications of policies and the other from laissez faire attitudes toward diversity supports. Some interviewees described managers who are uncomfortable with the flexible application of policies, an approach often adopted to support a diverse workforce. For example, immigrant workers might save up vacation time over several years so they can visit family for a month at time. Such an arrangement is understandably a challenge for the managers who have to rationalize equitable benefits to their staff and also rally remaining staff to fill the uncovered shifts. However, this type of flexibility may be critical to retaining workers with important linguistic and cultural skills. The other manifestation of this dilemma seems to occur when people confound "doing good" with supporting diversity. A couple of interviewees described organizational leaders who have adopted a stance that their commitment to fairness is embodied in their choice to work in a community health center, and who thus neither take time nor see the need to look critically at the organization or to personally commit to specific actions focused on diversity – leading, at best, to a fairly passive approach to addressing the needs of diverse workers.

  > *"I think we hire a lot of people who are here because of the mission and they really just do not want to hear of anything else. 'I'm a really good person because I work for [the health center]. How can I possibly be mean to someone else or dismissive of someone else? You can't be talking about me because I work here.' "*

- Well-intended approaches can have unintended consequences
  In order to celebrate the diversity of staff in a hectic work environment, some centers have implemented "Diversity Days." These events celebrate all nonwhite ethnic/racial and cultural groups together. The events can be quite festive, and interviewees reported that they build a sense of community and awareness across different cultures. At the same time, such events can be experienced as dismissive of the uniqueness of the various participating cultural groups. The concerns is that when all non-dominant groups are celebrated together, it tends to highlight their status as different from the white norm, and important differences among – and, just as importantly, *within* - ethnic/racial groups get little attention.

Promising Practices

Many CHCs have adopted practices that make a difference in meeting the challenges outlined above. In both the questionnaire and the interview responses, participants identified tools and strategies they have found particularly useful in moving toward their diverse staffing goals. The information gathered points towards policy implications that can affect positive changes in representational (including both recruitment and development of diverse staff), interactional (including daily exchanges among diverse coworkers) and work environment practices (including practices that promote an organizational climate supportive of diversity).

Representational Practices

Promising practices aimed at increasing the diversity of staff at all levels involve both active recruitment (i.e., identifying and reaching out to qualified candidates from diverse backgrounds) and creative approaches to staff development (i.e., working with existing staff to enable diverse staff to grow and become increasingly effective employees).

Recruitment: CHC representatives reported several strategies they use to *recruit* diverse staff for all levels of their health centers. Strategies include recruiting from the local community, using creative outreach approaches, and fostering advancement of current staff.

- Hire for potential; then provide support to meet that potential

  The CHC directors and HR managers we contacted uniformly recognize the rich ethnic/racial and cultural diversity within the areas they serve. Moreover, they are keenly aware that the residents of these communities often possess the multicultural and multilingual skills needed to provide effective health care. Although hiring from the local community is accompanied by the challenges mentioned above regarding finding workers with appropriate skills, several centers mentioned that they have an explicit focus on *hiring for potential.* Rather than screen primarily for past work experience and pre-existing skills, CHC representatives have found that they can increase diversity if they work to identify community applicants who have the potential to learn needed skills. When they take this approach, they acknowledge that they have to pair it with the provision of support to those employees in order to help them achieve their potential.

  "I think that we all have a responsibility as people who work in the field to recognize a spark when you see it in somebody, and say, 'this is my obligation. This is the way I can build the diverse workforce.' "

  "I think the health center is really committed to getting people to just keep growing…when we see people who are committed to the mission, and dedicated to their jobs and to the community, [we ask] how do we keep them and keep them growing."

- Promote from within

  A theme that emerged from many of the CHC interviews is the adoption of a "grow your own" philosophy. Several CHC representatives recounted success stories of entry level staff who were motivated to move into higher level medical or administrative

  "We had so much difficulty recruiting, that we decided to produce them ourselves. So it sort of gives us the first crack at good people."

positions and who embraced additional training and educational opportunities. These centers recognize the value of investing resources in current ethnic/racial minority employees and provide mentoring to prepare them to qualify for leadership positions. With this recognition and investment, *promoting from within* the organization has become a practice that can make a difference for diversifying staff beyond the entry level.

- Utilize targeted pipelines for recruitment of diverse professionals

  Tapping into ethnic/racial networks, institutions, and personal networks of current employees in the local community has been a successful approach to recruiting for diversity. This approach is particularly effective for entry level staff. A few centers reported success identifying qualified managers of color by hiring diversity-focused search firms. Another strategy adopted by a few CHC administrators is to sponsor training and internship programs that attract ethnic/racial minority trainees who then may be motivated to seek jobs in community health. Such programs are utilized for many types of positions from nurses' aides to nurse practitioners to doctors.

  "It is easier for us to recruit from the community than it is for many organizations…because we are a part of the community. We know the community."

Staff Development: Philosophies related to hiring for potential or "growing our own" must be built upon a foundation of a strong commitment to staff development. Promising practices include training to help diverse staff with critical technical skills combined with policies that facilitate access to this training.

- Provide training and mentoring to support diverse staff

  Although the specific formats and intensity vary, general training for all staff related to culturally competent and responsive patient care is common across centers. In addition, a few centers sponsor specialized classes to support ethnically/racially diverse staff. They recognize that hiring someone who is multilingual and multicultural does not ensure that s/he understands medical terminology in multiple languages. To address this challenge, several centers have adopted training specifically focused on fluency in medical terminology. Similarly, several centers offer classes on both spoken and written English for staff who need to process medical paperwork in a language they may not have fully mastered. Mentoring was also cited as a particularly effective method of supporting and informally training staff. When promising employees receive guidance and mentorship, whether formal or informal, it can provide critical instruction on the less tangible skills needed to succeed in the workplace, such as navigating difficult interpersonal issues or establishing work-life balance.

  "[For staff trainings] we adapted some of the longer cultural competency presentations…to raise consciousness around the issues of differences in culture. And we don't only talk about ethnic cultures; we talk about class, and social status and any other number of differences that can be found."

- Accommodate individual personal circumstances when possible

  Another realm in which many CHC leaders recognize the need to be creative is around accommodating the immediate needs as well as utilizing the unique talents of workers. Many valued CHC employees may not be able to work easily within traditional 9-5 work hours; some may have unique skills in an area that requires credentialing they do not possess; and others may be the sole caretaker of a family member and need some flexibility from their managers. CHC representatives described working with employees to refine work schedules that

accommodate the employees' family and/or transportation needs. Some examples include: shifting hours to accommodate dependent care needs, moving positions if a more flexible set of responsibilities is a better fit, or making accommodations for time for training for a more suitable position.

- Establish partnerships with colleges and universities
  Some CHCs have partnerships with colleges and universities to provide advanced education. Some CHCs have their own training programs for nurses. One CHC has partnered with a local community college to provide necessary college courses to supplement CHC-based trainings to help medical assistants develop into nurses. This partnership is perceived as a win-win arrangement since it brings more students into the college, provides educational opportunities for community members, and increases the diversity of the nursing employees in the center.

> *"We find that there are a lot of people finishing high school with significant deficits, especially in math and science. Because it's so competitive to get into nursing school, other systems that have had more resources and less issues have been able to have graduates at a higher level of math and science. So that's one of the things we do, we really try to level the playing field for our local candidates who want to get into nursing school."*

Interactional Practices

Most CHC representatives in the study understand that there is a potential for cultural bias and misunderstandings when workers from different cultures work together; most pay attention to promoting positive interpersonal interactions among diverse workers on a daily basis. The specific approaches that CHC administrators find effective range from taking swift action around any problems to creating settings to increase communication across differences.

- Proactively recognize the potential role of culture in interpersonal misunderstandings
  We found that most centers take interpersonal tensions seriously and recognize that such misunderstandings are often rooted in cultural issues. They understand that s*wift action* is needed so that such misunderstandings do not intensify. Centers have a wide range of protocols, many of which seemed to be effective. One particularly effective practice involves identifying an individual in a position of leadership with a reputation for being culturally sensitive and asking that person to act as a mediator. Allowing for frank discussion between the employees involved, mediated by a culturally-savvy manager, can permit both parties to be heard, help them to come to a resolution, and send a clear message that the CHC respects cultural differences.

> *"[In talking about interpersonal conflicts] You don't know whether it's because of who they are, where they're at, their culture, or just because they're two people who really don't like each other… but you have to deal with it from all those angles… there's so much culture in our organization that you can't ever discount that."*

- Establish settings that facilitate communication and promote inclusion of all staff
  Many CHC administrators recognized the importance of creating settings that promote communication and foster inclusion. Practices include establishing monthly open meetings with CEOs, setting aside a morning each week to close the clinics so everyone is available for meetings, and holding quarterly round table discussions about specific topics that highlight the diverse backgrounds of staff. Another set of approaches that promotes effective communication across differences aims is to establish work teams that cut across job functions, i.e., seamless work teams, so that communication flows smoothly from the front desk staff who are doing intakes, every step of the way to RNs, and MDs and then back again.

> *"[We've found] a better way to run a staff meeting… talking heads is not as good and as interesting for staff as asking them, 'So what would you do in this situation?'… You're asking for the answers from the group."*

- Provide training related to interpersonal relations at work
  In addition to establishing systems for dealing with misunderstandings in the workplace, some CHCs provide trainings to improve interpersonal relations among employees. For example, team building trainings include ways to respectfully communicate with diverse coworkers. Several CHC representatives described their efforts to communicate that cultural competence is taken seriously, and they make clear that establishing good working relations among diverse workers is part of the commitment to culturally competent service delivery. One CHC focuses their training on skills for being adaptable to anyone who comes through the front door - whether it's a patient or new employee and whether it's someone from a new ethnic/racial group or from one's own culture. This CHC tries to drive home the importance of staff continually asking "what are the central things I need to know about this person?" From that starting point, they teach employees to consider the historical context of particular groups, customs and beliefs, current health issues, and varied interpersonal styles.

> *"When we started our cultural competence efforts, part of that was because of a major change in not only our patients, but our staff… And from then on we began to develop the whole training component, so it starts at orientation and [continues]."*

Workplace Environment Practices

A third set of promising practices are those that revolve around promoting an overall work climate that supports diversity.

- Actively recognize differences and multiple realities among staff
  CHC administrators throughout Massachusetts have found a variety of ways to express the value they place on having diversity among their staff. This value is expressed by many centers in aspirational ways by including diversity in their organizational mission statements and in various documents, brochures, and proposals that indicate commitment to diversity at all levels of the organization. More daily manifestations of the value for diversity are the initiation of task forces, councils, and training programs that are designed to bring forth and validate how workers from varied ethnic/racial backgrounds experience the workplace. Several center representatives talked about the need to be cognizant of and visibly recognize the issues *within* varied ethnic/racial communities (e.g., differences among various Latin American groups; historical tensions or divisions between various Asian groups; the vast variability and political differences across African countries). One largely Latino-oriented center has entertained the idea of

providing training about white culture. Training programs as well as staff gatherings are used to seek out views of diverse employees.

- Avoid becoming a "blaming organization" by considering context
  Several center representatives emphasized the importance of treating cultural misunderstandings as understandable – even though they cannot be overlooked or dismissed as trivial. While using somewhat different language, several center administrators described their efforts to be understanding of how varied life, ethnic, and cultural circumstances affect employees at work – in other words, to adopt a contextual understanding of staff. A phrase used by one center director that captures this aspiration is that they strive to avoid becoming a "blaming organization." The approach involves adopting an organizational-level understanding that all staff are affected by their circumstances and the context of their ethnic/racial background, their current life situation, resources, etc. This stance includes understanding that what on first glance may look like personality differences or personal clashes, may be influenced by cultural differences, misguided assumption or biases, or other life circumstances. Understanding the varied contextual influences is antithetical to focusing on finding fault for tensions or miscommunications.

- Promote an organizational culture of connection
  Another promising practice cited by some CHC participants involves developing an organizational culture that is "kind." This is often operationalized as an organizational culture that emphasizes connection, where an active focus is both on shared goals and on the importance of working together to reach those goals. This emphasis has been deeply ingrained in the philosophy of the CHC movement since its beginnings, and while some worry that CHCs might be losing their grassroots energy as they become a vital part of the overall health care system, some CHC administrators have adopted practices to periodically remind people of the core values of the movement. When ideally implemented, an emphasis on an overarching vision keeps people's sights on the *shared goals*, accentuates the sense of "being in it together," and emphasizes what *strengths* each employee can contribute to achieving the organizational mission.

  > *"We have a lot of cultural celebrations. So we really encourage celebrating everyone's culture, and it reflects on, and makes us all realize the similarities as well as the differences between all the cultures and the different diverse backgrounds."*

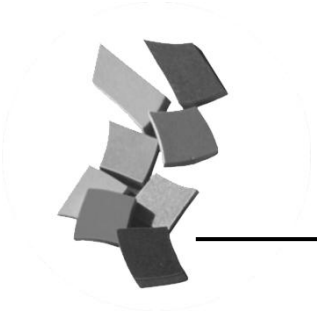
- Hold people accountable for *impact*
  Best practices pair attention to connection with a strong emphasis on interpersonal accountability. In fact, an emphasis on connection is an important tool in communicating that employees are accountable for the *impact* they have on others, i.e., where having good intensions is not a rationale for behavior that has a negative impact on coworkers. Part of establishing good work relations is being sensitive to how one's behavior is experienced by people from different ethnic/racial backgrounds.

- Adopt a priority for *equitable* (vs. allowing "equal" to mean "identical") in policy development
  Some CHC leaders find it important to emphasize that treatment that is "fair and equitable" might not necessarily be identical. Sometimes accommodations must be made to support employees who come from widely varying circumstances. For example, one CHC employed a Vietnamese nurse who worked for two years straight without taking a vacation. She then asked for three

weeks off to visit family in Vietnam. While it is not typical for employees to take three week vacations, the CHC administrators accommodated such requests given the cost and time involved in the travel. Many of the CHC representatives acknowledged that having clear personnel policies is important but also that such policies need to be *flexible* to be responsive to varied life circumstances.

- Adopt savvy business practices to support diversity
  The literature on workplace diversity is filled with discussions about how "diversity is good for business."[27] In our interviews, we encountered an important corollary- "good business practice supports diversity." Several interviewees described how their efforts to generate, access, and share resources have increased their ability to fund recruitment and training for diverse staffing – and such efforts can enable a center to offer more competitive salaries. Some such practices described by participating CHCs include the development of alternative sources of income, becoming very well informed and coaching staff about various educational grants and benefits like tuition reimbursement programs, and partnering with other CHCs to share training curricula.

  "And we have a great respect for cultural competency and that's not true in every environment you work in… we value it as a skill."



5. Recommendations

We distilled specific action recommendations based on input from the participating community health centers – including possible public policy directions that would facilitate efforts to hire and promote for diversity. We asked the CHC interviewees what kind of supports would be helpful in initiating or enhancing diversity initiatives, both as part of the questionnaire and in the interviews. The following recommendations include actions that can be taken by individual CHCs, the Massachusetts League of Community Health Centers, policy makers, and funders.

- **Increase supports for recruitment**

  Many CHCs could benefit from support that would allow both the time and the budget necessary to recruit top ethnic/racial candidates. The need to fill positions quickly can result in hiring from a less diverse pool of candidates if CHCs lack an efficient way to identify qualified applicants. Some possible actions include:

  - Broaden coordination and support among CHCs and from the Mass League in posting jobs in ways that will reach ethnic/minority communities. Many CHCs already coordinate very effectively, and the Mass League is seen by many as a valuable resource in this regard. However, many centers still struggle to identify qualified applicants. Hosting periodic forums for CHCs to share effective recruitment strategies with one another could be useful. Recruitment outreach into immigrant communities also requires a nuanced understanding of the cultural institutions and neighborhood media outlets that will reach qualified members of those communities. For entry-level jobs in particular, further coordinating access to ethnic/racial minority media around the state to help with recruitment and ensuring that all CHC administrators know about this resource would be valuable.

  - Expand dissemination of information about external recruitment resources for leadership positions. The development of a state-wide data base of resources for diversity recruitment (such as ethnic minority professional associations) could help CHC managers in better locating ethnically/racially diverse candidates for medical and administrative leadership positions. Shared access to diversity-focused recruitment consultants that specialize in non-profits could potentially help bridge the gap between needing to hire quickly and prioritizing diversity. Coordination among CHCs could enable them to negotiate better rates. Additionally, broader outreach *within* the CHC itself to fill available leadership positions could draw unexpected interest from diverse employees beyond those the administration already believes are interested.

  - Strengthen and coordinate relationships with educational institutions to foster an ongoing diversity pipeline for CHC personnel – even reach beyond Massachusetts in this effort. Working together to identify and build relationships with a diversity pipeline could help expand the pool of ethnically/racially diverse candidates for all CHCs. A coordinated public relations campaign on behalf of Massachusetts CHCs could be worth the investment. Furthermore, increased CHC presence at university job fairs could help draw interested individuals into the health care field.

- ❖ Expand the use of employee referral programs. Many CHCs provide incentives to current employees who refer qualified applicants; additional centers might benefit from the use of such programs. Programs such as these encourage employees to be proactive in fostering a culture of talent and diversity within their own workforce. Furthermore, when employees refer qualified candidates to open positions, it can further strengthen the ties between the CHC and the community it serves.

- **Establish user-friendly systems that make it possible to track staffing demographics and progress on diversity goals**

The importance of having a diverse workforce that reflects the range of ethnic/racial diversity within the community is widely endorsed. Many also recognize that staffing that matches or mirrors the linguistic and cultural diversity of the patient population is different from "diversity" and even more valuable. Some strategies for supporting CHCs' efforts to hire and staff for diversity and *match* include:

- ❖ Standardize reporting formats across funders and accrediting bodies. CHC administrators provide information on workforce demographics on a periodic basis to state and federal governmental agencies as well as to other funders. Required data can be difficult to capture and track, and required formats for the different funding and accrediting agencies differ. Developing a standard format (and standard definitions of commonly used terms) with input from CHCs on what and how to report demographics that would be accepted by many funders would save time, money, and energy and could increase compliance. This could also help CHC managers track diversity for internal use more effectively and thereby help them target areas for improvement.

- ❖ Support and build on the Mass League's efforts to track vital CHC information about staffing demographics and professional development needs. The Mass League is actively working on the issue of standardized reporting formats. Additionally, they have the interest and ability to include targeted questions about staffing demographics in their annual survey of CHCs.

- ❖ Encourage funders to regularly include staffing issues alongside patient-centered issues in all requests for proposals. Available funding for CHCs is typically – and appropriately - centered on improving care and outcomes related to specific health issues. Establishing supports for the recruitment and retention of qualified diverse staff are critical to augment patient-centered programs. Some funders routinely require information on staff demographics (e.g., Department of Public Health); others should be encouraged to do so. Ideally, funding to support workplace diversity initiatives would also be included.

- ❖ Actively disseminate strategies for establishing goals and tracking progress on efforts to enhance workforce-patient *match*. In addition to simply tracking numbers of staff by demographic category, CHC managers could benefit from access to standardized strategies for monitoring the *match* between who they are treating and who they employ. If the collection of demographic information can be streamlined, it could be used to help in setting goals and designing initiatives for improving workforce *match*; furthermore, such information is critical to enable CHC administrators to assess the effectiveness of their diversity efforts.

- ❖ Address misconceptions about the legality of documenting staff demographics and recognize implications of the fact that ethnic/racial self-identification is voluntary for both staff and patients. At least one center director did not participate in our survey due to concerns that it is illegal to report demographic data on employees. Although employers cannot require individual employees to disclose their ethnic/racial background, many funders require centers to report aggregate staff demographics.

- ❖ Balance efforts to set goals and track progress with awareness of the challenges in addressing demographic *match* between staff and patients. While CHCs may benefit from tracking their progress on *match* and diversity goals, it is also important for everyone involved to understand that patient demographics can shift quickly as communities welcome new immigrant groups. This is particularly true in gateway communities, which have a natural and yet often unpredictable flux in the demographics of the community. Further, if CHC turnover is low (as some interviewees indicated), the shifting demands of hiring for *match* are not easy to accommodate quickly. Furthermore, an expanded view of "community" needs to be taken into account for certain centers. Some CHCs draw more widely in terms of geographic location and do not serve only the immediate area. Some draw patients based on specialties (e.g., HIV care, GLBT issues, Asian populations), and patients will travel large distances for this specialized care.

- ■ **Expand supports for staff training (within centers, statewide, regionally, and nationally)**

Providing on-going, affordable training both to enhance the skills of ethnic/racial minority staff and to enhance the skills of all staff in dealing with a diverse workforce are essential to supporting diversity staffing goals. There are already some excellent workshops available; some potential strategies for expanding offerings and enhancing accessibility include:

- ❖ Offer ongoing training for supervisors, particularly around skills for managing a diverse workforce – beyond one-shot workshops. Trainings could include: management skills; leadership development; team-building and dealing with diversity in work teams; diversity in general. Ideally, training would also include support for supervisors in problem solving around current challenges. Creating a web-based directory of experts within Massachusetts who can provide *affordable* training sessions on such topics could help in making these trainings more accessible and sustainable for individual CHCs.

- ❖ Encourage CHCs to offer regular training and supports to enhance all staff's ability to work effectively across cultural, racial, gender, and sexual orientation differences. If CHCs can establish such training on a regular basis (e.g., anywhere from monthly to annually), it will be much more effective. Train the trainer approaches can help to foster the sustainability of such efforts.

- ❖ Expand mentoring programs as a method to support and guide employees. Mentoring programs allow less experienced staff to learn from more experienced and more established workers. Such programs can help with retention of staff with the cultural and linguistic skills needed by CHCs and also provide the professional development guidance that can prepare them for promotion within the organization.

- ❖ Expand language-based training and work on offering certification for medical interpretation. Many medical assistants and community health workers who are multilingual could benefit from more training in medical terminology. CHCs that have not been able to adopt such

training could learn a tremendous amount from – and coordinate with – the centers that have established programs. Furthermore, taking the steps to make certification available will support efforts to establish specific competency-based training outcomes. It will also support employees with the necessary skill set should they want to advance.

- Explore ways to make English language training that focuses on both oral and written language skills more widely accessible. Since English is the "business language" for most CHCs in the state, more could be done to make English language learner classes available for employees at all levels. Some CHCs have the capacity to offer classes in-house and may find that onsite classes are more cost effective. Other CHCs may find it more workable to coordinate with classes available in the community and would benefit from a centralized resource for identifying such classes. Those CHCs that offer onsite classes could open their classes up to other CHCs.

- Advocate for more funding to support training and coordinate funding efforts. CHC administrators know they need increased financial support for trainings – not only to fund the direct training costs but also to provide back-up coverage for the job responsibilities of the people who attend training. However, funding is not only scarce, but some funders do not field multiple proposals from individual CHCs. Rarely do current funding opportunities support professional development of ethnic/racial minority staff or training for staff on diversity issues. Collective advocacy for expanded funding at a state and/or regional level as well as joint proposal writing among CHCs for training resources could be useful.

- Coordinate to enhance proximity of training; explore the feasibility of a statewide training coordinator. Several CHCs talked about the need for training within easy travel distance to reduce costs and time away from work. Work-site based training is considered the most workable for staff, but it can also be the most costly in terms of administrative time and budget. The Mass League serves an important role in establishing a sustainable coordinated approach, both through their statewide offerings and their increase in regional offerings. Another promising approach currently adopted by some CHCs to stretch training resources is to coordinate with other centers close in proximity, or even neighboring hospitals, to help reduce costs. Some interviewees felt their centers would benefit greatly from a full-time in-house training coordinator who could focus on assessing and addressing staff development needs. A more coordinated and affordable approach was urged by one Executive Director who suggested that CHCs could pool their resources to hire a statewide training coordinator, who would assess the specific training needs of individual centers and then broker and coordinate training that could be offered on site.

- Expand use of alternative methodologies and formats for making training more accessible. Making training available on-line could enhance accessibility, and creating an online resource library could help fill development gaps. Allowing employees to utilize CHC computers would be important for those who lack access to this technology from home. In terms of the structure of some educational programming for advanced professional development, one issue that CHC administrators have to address is the extent to which training should be done during the work day and the extent to which staff should invest their own time. A strategy adopted by one center that could be further explored is having half the time spent on classes be work time and the other half personal time.

- ❖ Develop a focused campaign to increase awareness of opportunities for financing individual professional development. Some center administrators seem to be more aware of tuition reimbursement, loan repayment options, and other educational support programs than others. Information that explains these and related options through both printed and web-based media is available, but many still seem unaware. A creative awareness campaign targeting ethnic/racial minority staff could open up opportunities to a diverse group of workers interested in advancing their medical careers.

☐ **Foster educational partnerships**

Some CHCs have implemented programs that effectively address pipeline issues by partnering with existing educational institutions.

- ❖ Increase outreach to current college students and faculty to enhance the pipeline. The Mass League as well as individual CHCs work with some community colleges and universities to inform students about careers in community health. Additional efforts could further enhance the pipeline, with a particular focus on ethnic/racial minority students. For example, providing general information to current students about requirements for entering into health care fields and about the particular need for an ethnically/racially diverse workforce could help to guide diverse students to appropriate courses of study. Educating nursing students during their training about community health and what to expect in this field, can draw interested and qualified candidates into CHCs. Providing information to non-medical students who may be interested in the health fields could also help to attract committed personnel. Guest lectures, printed materials, and ongoing consultation with current faculty members could all be helpful. Coordinating internships for both medical and non-medical students can build ongoing relationships with colleges and universities. One interviewee commented on the value of such relationships: *It would be great if schools could actively move people to us ... call our HR department and say "I've got 4 great nurses coming out who speak Spanish."*

- ❖ Increase partnerships with educational institutions, hospitals, and other agencies to establish programs for developing the current CHC workforce. There are already several innovative training programs and educational partnerships across the state. State funding is needed for programs such as community health center medical residency programs and nurses training that have been shown to strengthen the skill set of the current workforce. These programs can also help in attracting top graduates of diverse ethnic/racial backgrounds to continue working at CHCs in Massachusetts. Establishing sustainable funding for the current programs is essential. Increasing awareness of these programs and identifying models for replication would also be an extremely valuable resource for all CHCs. Looking at national models could help guide efforts to expand these types of partnerships.

- ❖ Advocate for incentives for diverse students to enter health care careers. Encouraging individuals with bilingual/bicultural skills to actively consider careers in CHCs would strengthen the pipeline. Providing incentives like higher education scholarships for ethnic/minority individuals interested in health careers would be an excellent complement to other formal programs.

- **Promote organizational practices that support diversity**

  Participating CHC representatives mentioned that there are diversity-related practices that they find particularly effective. Support from the Mass League, other CHCs, and/or diversity consultants are potentially useful resources to encourage broader adoption of such practices. Some specific approaches include:

  - Encourage CHC leaders to proactively create settings for addressing diversity issues that emerge in the daily work of the center. Participating organizations described numerous examples of staff meetings, retreats, training opportunities – even emails – that they use to raise issues related to diversity in ways that are responsive to staff questions and needs. Emphasizing interpersonal accountability for the impact that staff have on one another is an important aspect of such settings. These settings do not need to be labeled as "diversity" sessions; the essential ingredients are that they are settings devoted to work-related interpersonal concerns and that the leader of the group is skilled at addressing the diversity-related dimensions of the concerns.

  - Reinforce the importance of defining "equity" to include responsiveness to varied circumstances (vs. being equated with *identical* treatment). One of the critical principles that helps many CHC managers to attract, retain, and develop diverse staff is their willingness to identify individual strengths and unique contributions. With that appreciation as a foundation, they work to make accommodations, provide training, and organize supports to help contributing employees thrive and grow. This is a valuable perspective that needs to be fostered and validated, particularly in times when resources are shrinking.

  - Encourage CHC leaders to be creative in their thinking about ways to educate staff about varied cultural traditions. Approaches that go beyond periodic cultural celebrations can be extremely useful in addressing nuanced differences among varied cultural groups and can keep issues related to ethnic/racial diversity alive all year round. The ideal approach is to find ways to weave attention to diversity into every activity of the center. Establishing opportunities for CHC leaders to share strategies could be extremely useful.

  - Provide consultation on strategies for institutionalizing diversity-oriented practices. In particular, some centers asked for help with establishing a diversity committee or task force. The use of such groups to guide and oversee diversity goals was seen as useful, but some centers were unsure about how to begin the process. Consultation could be useful around such issues as how to structure the group, garner center-wide support, frame committee goals, establish operating procedures, and ensure sustainability. The goals, objectives, and methods of these committees will most likely be unique to each center, but information about various models and help with the early phases would be particularly beneficial.

  - Continue attention to and expansion of the U.S. Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards -adopted by the U.S. Department of Health and Human Services).[28] The CLAS standards were created to assist health care organizations to meet the needs of diverse patients and address inequities in health care services. While most of the standards are framed around the quality of direct patient care, these standards also validate the importance of attending to the organizational practices that support diverse staffing. One subset of recommendations focuses on organizational supports for cultural competence, which includes recruiting and retaining diverse staff at all organizational levels (Standard 2),

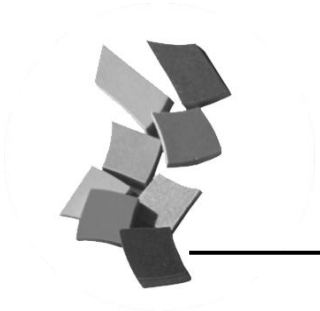
ensuring the cultural competence of staff through training (Standard 3), developing diversity-related strategic plans (Standard 8), and conducting regular organizational self assessments vis-à-vis cultural competence (Standard 9). If there is a revision of these standards, we recommend strengthening the emphasis on staffing issues.

- **Address payment reform**

  Examine current state and federal payment systems for potential opportunities to expand reimbursement. Advocate for changes in requirements – and for expanded certification for some services -- to better align payment and delivery systems.

  - Advocate for coverage of ancillary services, such as interpretation, social services, and/or transportation. CHC patients typically present with multiple health and social challenges. However, payment is provided per physician visit with no consideration for the length of the visit, the complexity of the care, or the necessary ancillary services. CHCs are not reimbursed for the "extras," yet they still need to cover those costs. The transition to more integrated forms of health care delivery is a strategy that offers a way to contain costs, enhance coordination, and increase quality at the same time. In addition, revising reimbursement strategies – from Medicare, Medicaid, and private insurers -- to allow for billable time that truly reflects the multifaceted work with patients would increase the CHCs' ability to hire and retain diverse staff in a competitive market.

  - Advocate for additional funding sources for interpreter services. Increased recognition of the importance of – and lack of funding for – interpretation services is critical for supporting staffing that can meet the needs of diverse patient populations. The ideal is to have on-site staff who are trained and readily available to provide such services; however, many multilingual staff also have other important work duties to attend to. The stress these additional interpretation demands can put on staff with the needed cultural and linguistic skills can be intense. Phone-based and contract services are thus also essential. Yet none of this service time is reimbursable at the present time; none is covered by Mass Health or other sources. The Mass League has negotiated with phone-based companies that provide special rates to CHCs. CHCs in our study said this arrangement is a significant help, but the costs can still add up to a large portion of a CHC's budget, particularly among those centers that serve a wide range of linguistic groups. Reform in the reimbursement structure would be extremely helpful in providing support for the very staff CHCs need to be hiring.



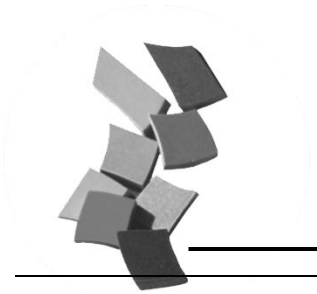
6. Conclusion

With the current intense discussion of health care at the state and national levels, it becomes ever more essential to understand the resources that community health centers need in order to hire and support staff who can offer quality, effective, and equitable care to our most vulnerable populations. Critical aspects of this challenge are to attract and retain a workforce that reflects and understands the ethnic and cultural diversity within the populations that they serve. This report has summarized some of the challenges faced by CHCs in their dedicated efforts to ensure that their health care providers are diverse. The report highlights some very promising practices adopted by current CHCs and concludes with recommendations for action at the organizational, regional, and statewide levels.

Additional Information

For additional information and to learn more about the Healthy Diversity Project, please visit our website:

http://www.uml.edu/centers/women-work/Healthy_Diversity.html



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Appendix A

PART I: HEALTHY DIVERSITY SURVEY

The purpose of this survey is to better understand the ways in which your Community Health Center approaches diversity among your employees. Attached is Part I of the study; Part II asks about important demographics and will be sent to you as an excel file under separate cover.

Your responses will be held in confidence and will provide important information about both challenges and best practices for diversifying the CHC workforce in Massachusetts.

The survey is being sent to CHC Executive Directors/CEOs, but can be completed by whoever within your organization is best informed about these issues (e.g., you may opt to ask your HR Manager to complete the survey).

What follows is a series of questions about **workplace diversity policies and practices**. Please answer these questions with respect to your current staff. The survey is divided into sections that address the following:

1) Recruitment, Selection, & Retention
2) Organizational Policies & Practices
3) Diversity of Leadership
4) Training & Development
5) General Diversity Climate & Practices

The survey looks longer than it is because there is a lot of white space for you to write comments if you wish – it should take you about 45 minutes to complete.

Your responses will remain confidential; results will be summarized in a general way in order to conceal individual organizational identities. However, we do need to match your responses to this survey with the information we are gathering in Part II about your local community and CHC workforce demographics.

Thank you in advance for participating in this important survey!

Section I: Recruitment, Selection, & Retention

The following questions ask about recruitment, selection, and retention strategies geared towards promoting a diverse workforce.

1. In addition to professional journals, newspapers, and websites such as Craig's List, please indicate the extent to which you utilize any of the listed strategies to identify a diverse pool of ethnic/racial minority job candidates. We are interested in strategies broken down by staffing category.

Please circle the number that best represents how often you utilize the following strategies (1 = NEVER; 5 = ALWAYS) to recruit a diverse applicant pool for:

a) Executive Staff: CEO/Executive Director, Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, Chief Information Officer

EXECUTIVE STAFF Recruitment Efforts	**N**				**A**
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

b) Clinical Providers: Doctoral/M.D., Dentists, Psychologists, Psychiatrists, Nurses, Social Workers

CLINICAL PROVIDER STAFF Recruitment Efforts	**N**				**A**
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

c) Directors/Managers: Directors, Managers, Supervisors within programs or departments (below executive staff)

MANAGERIAL STAFF Recruitment Efforts	**N**				**A**
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

d) Technical Staff: Lab techs, x-ray techs, other technical positions

TECHNICAL STAFF Recruitment Efforts	N				A
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

e) Clinical Support Staff: Medical Assistants, Dental Assistants, other

CLINICAL SUPPORT STAFF Recruitment Efforts	N				A
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

f) Community Health Workers: Workers who provide direct services and culturally appropriate care and access to services

COMMUNITY HEALTH WORKER STAFF Recruitment Efforts	N				A
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

g) Administrative Support: Receptionists, Administrative Assistants

ADMINISTRATIVE SUPPORT STAFF Recruitment Efforts	N				A
Informal networks (e.g., places of workshop, community bulletin boards, word of mouth)	1	2	3	4	5
Formal networks (e.g., educational programs, healthcare networks, search firms)	1	2	3	4	5
Advertisements in ethnic media (e.g., ethnic newspapers, radio, tv, and/or websites)	1	2	3	4	5
Advertising in multiple languages	1	2	3	4	5
Advertisements in ethnic media	1	2	3	4	5
Other: (please specify)	1	2	3	4	5

2. Overall, what are the top three recruitment strategies that yield the greatest number of qualified ethnic/racial minority candidates?

3. Are some strategies more effective with specific ethnic/racial minority groups?
   YES NO

   If YES, please explain by providing an example:

4. Have you found some strategies to be more effective in recruiting ethnic/racial minority workers for specific job levels/job types?
   YES NO

   If YES, please explain by providing an example:

5. What do you see as the primary barriers/challenges to RECRUITING AND SELECTING an ethnically/racially diverse workforce?

6. What do you see as the top 3 barriers/challenges to RETAINING ethnic/racial minority workers in your organization?

Section II: Organizational Policies & Practices

1. Does your CHC have a statement of values and/or strategic goals that includes diversity and inclusion within the staff?
   YES NO

If YES, please describe or include statement here:

2. Is there a person and/or committee whose primary responsibility is the oversight of initiatives related to workforce diversity in the organization? Please check all that apply:
   YES NO

   If YES, please check all that apply:
   - _ CEO/Director
   - _ HR Manager
   - _ Other Person
   - _ Committee
   - _ Other:_____

3. Does your CHC formally assess its own performance with respect to achievement of diversity staffing goals?
   YES NO

   If YES, how often?

4. Is there a formal employee conduct code that advocates for respectful treatment of ethnic/racial minority employees?
   YES NO

   Comments:

5. Is there a formal grievance procedure for employees to address ethnic/racial discrimination, harassment, or prejudice?
   YES NO

   Comments:

6. Are there religious accommodations made for cultural/religious minority employees?
   YES NO

   Comments:

7. Is there an affirmative action policy in place geared towards ethnic/racial minority employees?
   YES NO

8. To what extent do you think your ethnic/racial minority employees are aware of the various polices in place to foster an inclusive work environment? (1=Not at all; 5= Very much)

Not at all	1	2	3	4	5	Very Much

Comments:

Section III: Diversity of Leadership

The following questions ask about strategies geared towards fostering diverse leadership in your organization.

1. To what extent are you satisfied (1 = Not at all, 5=Very Much) with the ethnic/racial diversity of the organizational leadership at the:

   a. Executive level (CEO/Executive Director, Chief Financial Officer, Chief Operations Officer)

Not at all	1	2	3	4	5	Very Much

   b. Professional level (Doctoral/M.D., Dentists, Psychologists, Psychiatrists, Nurses, Social Workers)

Not at all	1	2	3	4	5	Very Much

   c. Managerial level (Supervisors within programs (below executive staff)

Not at all	1	2	3	4	5	Very Much

2. To what extent is ethnic/racial diversification of the leadership a strategic goal of the organization (1 = Not at all, 5 = Very Much)?

Not at all	1	2	3	4	5	Very Much

3. How often does your CHC employ the following strategies in order to foster ethnic/racial diversity in your leadership positions? (1 = NEVER; 3= SOMETIMES; 5 = VERY FREQUENTLY)

STRATEGIES for fostering diverse leadership	**Frequency**
Promote ethnic/racial minorities from within the organization	**1 2 3 4 5**
Encourage ethnic/racial minorities to apply for leadership positions	**1 2 3 4 5**
Conduct targeted ethnic/racial minority recruitment for leadership positions from outside the organization	**1 2 3 4 5**
Provide mentoring specifically targeted towards leadership development of ethnic/racial minority employees	**1 2 3 4 5**
Other (please describe):_____	**1 2 3 4 5**

Comments:

4. Many issues can present barriers to achieving **ethnic/racial diversity in leadership positions.** Please rate the extent to which each of the following issues is a barrier in your CHC (1 = Not at all, 5=A great extent)

BARRIERS to diversifying leadership	**EXTENT present in your CHC**
Few ethnic/racial minority candidates to promote from within	**1 2 3 4 5**
Lack of access to ethnic/racial minority candidates from outside the organization	**1 2 3 4 5**
Issues arise around different ethnic/cultural leadership styles	**1 2 3 4 5**
Cross cultural misunderstandings within teams	**1 2 3 4 5**
Limited understanding of cultural diversity/other cultural traditions	**1 2 3 4 5**
Ethnic/racial minority candidates lack U.S. necessary board certification	**1 2 3 4 5**
Ethnic/racial minority candidates lack needed language skills	**1 2 3 4 5**
Ethnic/racial minority candidates lack needed technical skills	**1 2 3 4 5**
Diversifying leadership not a priority for current managers	**1 2 3 4 5**
Diversifying leadership not a priority for the CHC Board	**1 2 3 4 5**
General organizational resistance to ethnic/racial minorities in leadership roles	**1 2 3 4 5**
Other (please describe):	**1 2 3 4 5**

Comments:

Section IV: Training and Development

The following questions ask about training opportunities and development strategies geared towards promoting a diverse workforce.

1. Have you identified any patterns of unique training and development needs among your ethnic/racial minority employees?
   YES NO

   If YES, please describe:

2. What do you do to try to address those particular training & development needs? Please check all that apply
   - ☐ Job specific training
   - ☐ Language proficiency training
   - ☐ Formal mentoring programs
   - ☐ Access to informal mentoring
   - ☐ Training on cultural competency with clients
   - ☐ Training on cultural competence for working with diverse coworkers/ teams
   - ☐ Teambuilding
   - ☐ Other_____

3. Who from your ethnic/minority workforce typically attends such programs or takes advantage of such supports?
   - ☐ Employees at all levels
   - ☐ Employees at only some levels (please describe:_____)
   - ☐ Other (please describe)_____

4. For those ethnic/racial minority employees who do not take advantage of the supports offered in your CHC, please rate the extent to which the following reasons apply (1= Not at all, 5= A great extent):

BARRIERS to take advantage of supports offered	**EXTENT present in your CHC**
Not interested	**1 2 3 4 5**
Too busy with work obligations	**1 2 3 4 5**
No back-up coverage	**1 2 3 4 5**
Location is not convenient	**1 2 3 4 5**
Family obligations	**1 2 3 4 5**
Not offered during paid time	**1 2 3 4 5**
Not offered in preferred language	**1 2 3 4 5**
Concern about not being English proficient enough	**1 2 3 4 5**
Other (please describe):	**1 2 3 4 5**

5. Do you sponsor any mentoring programs that specifically benefit ethnic/racial minorities?
   YES NO

   If YES, please describe any **FORMAL** mentoring programs and provide an example:

Also, please describe any **INFORMAL** mentoring programs and provide an example:

6. Are there any other training and development supports for ethnic/minority workers that this survey has not covered?
   YES NO

   If YES, please describe:

7. Are trainings available to **ALL staff** that address skills for **FOR WORKING WITH DIVERSE WORK TEAMS** and/or coworkers (i.e., cultural competence for coworker/team relations)?
   YES NO

   If YES, please describe:

   If YES, are they mandatory for staff at all levels? (Please check one)
   - ☐ Not mandatory
   - ☐ Mandatory for all staff at all levels
   - ☐ Mandatory for some staff but not others, please describe:_____

8. Are other types of forums or events open to **ALL staff** that promote cultural/ethnic/racial understanding among staff?
   YES NO

   If YES, please describe:

SECTION V: GENERAL DIVERSITY CHALLENGES & PRACTICES

Thank you for making it this far in the survey – there are <u>only 2 questions</u> left. In your previous answers, you have addressed a wide range of issues. For these last two questions, we ask you to provide your overall perception of the MOST important 1) challenges and 2) best practices. Please do not worry if your answers here overlap to some extent with anything you have written above.

1. If you think about all of the staffing issues that your CHC faces, what are the top 3 challenges (from recruiting to managing ongoing relationships) RELATED TO FOSTERING A DIVERSE WORK ENVIRONMENT AT YOUR CHC?

2. What are the top 3 (most successful, visible or well received) THINGS YOUR CHC DOES to promote diversity, inclusion, and racial and ethnic equality?

THE MASSACHUSETTS LEAGUE OF COMMUNITY HEALTH CENTERS

The Massachusetts League of Community Health Centers provides invaluable assistance to community health centers on a variety of levels and towards many of the goals outlined in this report. Below are a few of the ways in which the Mass League works on behalf of CHCs. For a full list of programs and initiatives, please visit www.massleague.org.

Support for recruitment of diverse staff:

- Facilitating communication among CHCs when positions become open
- Convening regular meetings among HR Managers to discuss issues of shared concern
- Working with colleges and universities to promote involvement of diverse students, e.g., though student internships with CHCs

Facilitation of training and educational opportunities relevant to diverse staff and diversity issues more generally:

- Sponsoring training on managing diverse staff and enhancing management skills in general
- Providing training for staff on teambuilding, leadership skills, and management strategies
- Sponsoring mentoring programs
- Actively working to generate funds to provide trainings
- Expanding and strengthening current outreach and communication systems among and between CHCs

Support for advanced formal education:

- Strengthening collaborations between CHCs and educational institutions
- Educating CHCs about the available financial supports for higher education
- Collaborating with CHCs to write and submit joint proposals for funding for educational opportunities
- Leveraging public and private funds for loan repayment programs

Advocacy for reforms that will better enable CHCs to hire the diverse staff that they need:

- Partnering with CHCs and outside groups and agencies to work on healthcare payment reform
- Advocating for ancillary services (interpretation, social services, etc.) to be addressed in global payments and future payment reform systems

For additional information and to learn more about the Healthy Diversity Project, please visit:

www.uml.edu/centers/women-work/Healthy_Diversity.html

UMASS LOWELL

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UMass Lowell