Progress or Performance? A Critical Analysis of Healthcare Organizations' Efforts to Address Diversity, Equity, and Inclusion and Health Equity in the Healthcare Workforce

by

Tiffany Cornwall

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Doctoral Committee:

Professor Denise Anthony, Chair
Nicole Cooper, United Way Worldwide
Associate Professor Melissa Creary
Professor Lindred Greer

Tiffany A. Cornwall

tpeart@umich.edu

ORCID iD: 0000-0002-4179-6274

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Dedication

This dissertation is dedicated to my late father, Osmond Peart, whose life was cut short due to the racist and flawed U.S. healthcare system. Dad, I hope I have made you proud. May this work contribute to a lifetime of striving for equity and making the world a better place.

Acknowledgements

The bottom line is this: You write to change the world, knowing perfectly well that you probably can't, but also knowing that literature is indispensable to the world. The world changes according to the way people see it, and you alter, even by a millimeter, the way people look at reality, then you can change it. If there is no moral question, there is no reason to write.

-James Baldwin

Growing up in East Orange, a community with one of the highest poverty rates in New Jersey, I never imagined pursuing a PhD or understood what it would entail. Raised by Jamaican parents, I was fortunate to have them build a mini classroom in our home and remind me and my sisters every day that we could achieve anything we set our minds to. Their belief in the power of education and their dedication to learning laid a strong foundation for my journey.

I do not take my parents' sacrifices lightly. I am deeply aware of what it means to be a Black girl, from a poor immigrant household, who has become the first in her family to earn a doctoral degree. It is both a privilege and an honor to achieve this milestone, and to have parents who, despite not knowing the specifics of earning a PhD, were immensely proud that their daughter would become a doctor. I extend my heartfelt gratitude to my mother, Ann Peart, and my late father, Osmond Peart, for their sacrifices beyond measure that provided me with the gift of a strong education. Dad, though you are not here to celebrate this milestone with us, I know you are with me in spirit. Your legacy continues to inspire me to lift others as I climb.

To my husband, Kevin Cornwall, I could not have pursued this degree without your partnership, support, and encouragement. Since the day we met, you have stood by my side, inspiring me to dream even bigger whenever my ideas felt too ambitious. From assisting with participant recruitment for my research study at Spelman to helping me refine my interviewing

skills for my dissertation and enduring the Michigan cold alongside me for all these years, my gratitude extends far beyond what words can express. You make me feel like the best version of myself everyday. Thank you for keeping me grounded during times when I was being too hard on myself, and for pushing me to apply when I did not think I would be accepted to a PhD program at all. And to my in-laws, Hether Cornwall and late father-in-law, Ian Cornwall, thank you for treating me like your own daughter and encouraging me to stay focused on my goals.

To my sisters, Stefanie and Britney, being your oldest sister is one of my greatest privileges. Thank you for taking every call, listening to every idea, and correcting our parents when they got my dissertation topic all wrong. I hope that I made you proud, and that my resilience while in the academy encourages you to pursue anything you set your mind to. No school is too hard for you to get into. No job is out of reach. You are qualified and prepared and brilliant. Our sisterhood is one of the greatest gifts and whenever I felt alone in the program, I knew that I had you both to support and encourage me.

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Lastly, I want to express my appreciation to my high school, the Oldfields School. After being wrongfully expelled, the students rallied to have me reinstated due to my significant impact on the school community. This support helped me become the third Black girl to ever be elected as School President, despite your attempts to shame and humiliate me for not fitting the school's perception of who should attend (and represent) the institution. I went on to attend Spelman College, an institution dedicated to empowering Black girls to believe they can change the world, and eventually pursued doctoral studies at the University of Michigan. If that is what it means to be a "nobody," then I am proud to fit the bill. To anyone who has faced systemic inequity in the education system and is reading this dissertation, I hope it encourages you to dream beyond any limitations and pursue your highest aspirations.

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Abstract

For years, scholars have studied the impact of race and racism on the clinical workforce. However, less attention has been given to understanding how race and racism has been *historically and structurally* built into healthcare organizations and the implications this has on the healthcare administrative workforce. This oversight affects: 1) the recruitment and retention of a diverse administrative workforce, 2) the development of effective diversity, equity, and inclusion (DEI) and health equity strategies, and 3) the training and development of early career professionals.

The COVID-19 pandemic and the "racial reckoning" of 2020 highlighted the need to address these issues. The pandemic disproportionately affected Black, Latino, and Native American communities, while anti-Asian racism surged. The killing of George Floyd sparked national protests and calls for organizations to adopt anti-racist policies. Disparities in healthcare leadership are stark: 98% of hospital CEOs are white, 87% of hospital boards lack diversity, and fewer than 5% of physicians identify as Black. Although organizational scholars have begun to explore reasons for the slow progress toward workforce diversification, gaps remain, particularly regarding the consequences of healthcare organizations confusing health equity with diversity, equity, and inclusion (DEI). What does it mean when organizations fail to understand the difference? Does this confusion negatively impact healthcare workforce diversity?

This dissertation uses a qualitative approach to examine the healthcare administrative workforce at three career stages: early, mid, and late career. The first paper evaluates the integration of DEI and health equity principles in healthcare administrative fellowship programs and analyzes job advertisements for racial and gender biases, revealing a troubling lack of prioritization and persistent biases. The second paper explores how middle management roles and hierarchical positions affect perceptions of

organizational progress toward advancing health equity. While middle managers generally view progress positively, they struggle to measure outcomes effectively. The third paper investigates the role of race and racism in strategic goal-setting and its impact on Black Chief DEI and Health Equity Officers. Findings show that these leaders often feel tokenized, unsupported, and face racism, leading to widespread dissatisfaction in their roles.

This dissertation demonstrates the critical need to recruit and retain diverse administrative talent and dismantle racist policies and procedures within healthcare organizations. Such changes are essential for improving employee experiences—particularly for people of color—and addressing racial disparities in health outcomes. It also serves as a call to action during a politically charged period when efforts to undermine and erase DEI and health equity initiatives are intensifying in the United States.

Chapter 1 Introduction

According to the 2018 U.S. Census report, the year 2030 will be a significant demographic milestone for the United States, as the nation is projected to experience substantial aging of its population and increasing racial and ethnic diversity (Vespa, Medina, Armstrong, 2018). The population of individuals identifying as multiracial is expected to grow the fastest over the coming decades, followed by Asian Americans and Hispanic/Latino Americans (Vespa, Medina, Armstrong, 2018). Recent estimates from the U.S. Census Bureau indicates that nearly 40% of Americans now identify with a race or ethnic group other than white, marking a historic shift where the white population declined from 2010 to 2020 (Frey, 2020). This increasing diversity will profoundly affect various aspects of American life, including the workforce, educational institutions, and social dynamics.

Despite overall improvements in health indicators such as life expectancy and infant mortality for many Americans, racial and ethnic minorities continue to face a disproportionate burden of preventable diseases, deaths, and disabilities compared to non-Hispanic White populations (Yearby, Clark, & Figueroa, 2022; Mitra, Long-Bellil, Moura, Miles, & Kaye, 2022). Historically, and even today, the health status of minority populations—such as African Americans, Native Americans, and more recently, Hispanics and some Asian subgroups—has not equaled that of their white counterparts (Smedley, Stith, & Nelson, 2003). Particularly for Black Americans, health and healthcare disparities are prevalent and significantly impact overall well-being. These disparities have been exacerbated by the COVID-19 pandemic, persistent racism, ongoing discrimination, and systemic violence against Black communities (Alang, McAlpine, McCreedy, & Hardeman, 2017; Bleich et al., 2019; Reyes, 2020). Furthermore, the enduring health disparities experienced by Black communities are deeply rooted in historical injustices

such as slavery, segregation, and mass incarceration, which continue to affect their lives today (Baciu, 2017).

For three decades, national reports on U.S. healthcare have emphasized the disparities and inequities in healthcare delivery to systematically disadvantaged populations, bringing attention to the urgent need for equitable healthcare access. The Institute of Medicine's 2001 report, "Crossing the Quality Chasm: A New Health Care System for the 21st Century," identified significant gaps in quality of care for people of color. The 2002 report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," identified root causes of racial disparities (Betancourt & Maina, 2004; Smedley, Stith, & Nelson, 2003). The Healthy People report aimed to reduce or eliminate health disparities in 2000 and 2010, but recent reports, such as Healthy People 2020 and 2030, now emphasize health equity which is closely tied to their focus on social determinants of health (SDOH) and health literacy (Office of Disease Prevention and Promotion, 2023). Recent reports have strengthened their emphasis on "upstream" factors like SDOH and health literacy because they have a major impact on people's health, well-being, and quality of life (Bharmal, Derose, Felician, Weden, 2015; Braveman et al., 2014; Palmer et al., 2019).

However, recent events, such as the COVID-19 pandemic, have sparked a national conversation about the role diversifying the healthcare workforce might play in reducing health disparities. The pandemic raised awareness around diversity in the workforce because of the disproportionate harm it caused historically marginalized groups. Black, Hispanic, and Asian people had substantially higher rates of infection, hospitalization, and death compared with White people (Rubin-Miller, Alban, Artiga, & Sullivan, 2020; Lopez, Hart, & Katz, 2021). Studies show having a workforce that reflects the diversity of the communities they serve improves access to care, builds physician-patient relationships, and provides culturally relevant care (Saha et al., 1999; LaVeist & Nuru-Jeter, 2002; Street, O'Malley, Cooper, & Haidet, 2008; Shen et al., 2018). The pandemic's devastating impact on communities of color clarified the need for diversity among healthcare workers and public health leaders (Wingfield, 2020; Woodruff, McDade, Nakae, et al., 2022).

Specifically, there is a growing awareness that the diversity of the health workforce has implications for access and quality for historically marginalized communities (Jackson & Gracia, 2014; Snyder, Frogner, & Skillman, 2018; Silver et al., 2019; Wilbur et al., 2020; Pittman et al., 2021). Recent studies have started to shed light on the severe consequences of predominantly white leadership teams (Dotson, Bonam, & Jagers, 2017; Ray, 2019). Executive position holders who lack exposure to diverse perspectives may develop “blind spots" related to racism and discrimination with organizations, which can perpetuate health disparities within the system and the communities it serves (Dotson, Bonam, & Jagers, 2017). In addition, leadership diversity also matters for talent development and grooming diverse future leaders in the longer term.

Initial work at the organizational level shows that when an organization emphasizes professional development for employees, organizational members feel more valued and respected (Ely and Thomas, 2001), and that such mentoring is key for elevating underrepresented leaders in the organizations (Creary, Rothbard, & Scruggs, 2021). Failure to engage in thoughtful dialogue with healthcare leaders of color may not only hinder their career progression, but also limit their ability to effect meaningful change within their organizations, perpetuating the cycle of underrepresentation and further entrenching health inequities. Therefore, to better serve the rapidly changing and increasingly diverse patient population, healthcare organizations must prioritize developing the diversity of their current and future leadership (Dotson & Nuru-Jeter, 2012).

However, health professions still face challenges in achieving diversity in their leadership, which perpetuate structural biases that compromise quality of care (Pittman et al., 2021) and lead to leadership teams of healthcare organizations which do not reflect the communities they serve. To date, 89% of all hospital CEOs identify as white, non-Hispanic or Latino (Johnson, 2024). A (2015) survey conducted by the American Hospital Association’s Institute for Diversity in Health Management found that 19% of lower- and mid-level hospital management positions, and just 11% of executive leadership positions, were held by people of color. This issue is particularly relevant as the U.S. is projected to become a “majority minority” nation by 2045, with the number of ethnic and racial minorities surpassing that of the

white population (Vespa, Armstrong, & Medina, 2018). One reason for this may be lack of understanding in health systems for the importance of more diversified teams for the advancement of health equity and diversity, equity, and inclusion (DEI) initiatives, the addressment of healthcare inequities, and ultimately system performance. Unfortunately, limited research has examined the impact of overwhelmingly white and gender homogenous teams in healthcare systems on these types of system outcomes.

The Urgent Need for Diverse Healthcare Leadership to Reduce Health Disparities and Advance Health Equity

To comprehensively address health care inequities, the dearth of racial and gender diversity in medicine and health care leadership must be fully evaluated. Despite underrepresented groups comprising more than 30% of the US population, less than 12% of physicians identify as Latinx or Black (Morris et al., 2021), reflecting a persistent and detrimental gap. For over a century, the share of Black physicians has consistently fallen below the African American share of the overall populations, with only 5.7% of physicians in the U.S. being Black or African American (Association of American Medical Colleges, 2023). Moreover, a mere 2.9% of medical students in 2019 were Black men (Morris et al., 2021) and less than 10% of medical students were Black women in 2022 (Sharp, Hixson, Stumpff, & Williamson, 2022).

The need for sustained action to promote diversity and inclusivity in healthcare is further underscored by the lack of diversity in executive and senior healthcare leadership positions, as evidenced by the Institute for Diversity in Health Management's (now Institute for Diversity and Health Equity) survey. To date, 89% of CEOS in the healthcare industry identify as white. According to their 2015 survey, only 9% of CEOs and 14% of Chief Medical Officers in hospitals were from historically underrepresented groups. For those from underrepresented groups who attain leadership roles, Chief Diversity Officer (CDO), Chief Health Equity Officer (CHE), or related positions are the most common.

The CDO and CHE positions have emerged as executive-level roles that provide strategic guidance for either diversity or health equity planning and implementation efforts. The growing number of these appointments has raised questions regarding the contributions and barriers to this position.

Experts have reported that positions dedicated to diversity, equity, and inclusion (DE&I) have quadrupled in the past five years in the United States, an no DE&I role is more visible than the chief diversity officer (CDO) (Goldstein, Manveer, Immose, & Williams, 2022). After George Floyd's murder, hirings for DEI officers surged by 55%, yet 60% of diversity officers left their positions between 2018 and 2021, with executives citing inadequate institutional support, budget, and career advancement (Goldstein, Manveer, Immose, & Williams, 2022). The average tenure of CDOs at large publicly-traded US firms is now less than 2 years, a concerning trend that is likely mirrored in healthcare (Huang, Tapia, & Polonski, 2023). We know even less about the average tenure of CHE positions, but it is likely they face similar obstacles in securing long-term positions of influence.

Racial and ethnic disparities in healthcare leadership were further highlighted in ACHE's 2014 survey, which revealed that minority health care executives were more likely than white counterparts to take less desirable positions due to financial need (29% of Black executives compared to 15% of white executives) and lack of opportunity (38% of Blacks compared to 24% of whites. Gender and ethnic disparities in career aspirations were also evident, with 42% of white men planning to become CEOs in 5 years, while only 32% of Black, 31% of Hispanic, and 11% of Asian men shared the same goal, and less than 30% of women aspired to become CEOs (ACHE, 2015). Furthermore, there were differences in the percentage of respondents who witnessed racial/ethnic discrimination in healthcare management careers, with 64% of Blacks, 35% of Hispanics, 32% of Asians, and 16% of whites reporting such incidents.

1.1 Problem Statement

Despite ongoing efforts to improve diversity in healthcare leadership, hospital C-suites and boards continue to be overwhelmingly white, perpetuating the lack of diversity in healthcare leadership and impeding our progress towards achieving health equity. This may stem from a lack of prioritization of diversity, equity, and inclusion (DEI) and health equity initiatives in professional development programs, as well as a lack of knowledge of how to successfully manage professional development pathways meant to diversify healthcare leadership, such as from critical analyses of fellowship program practices and

policies in relation to DEI and health equity. Insufficient budgetary support, inadequate staffing support, and a lack of understanding regarding organizational policies and priorities are additional factors contributing to the lack of progress in workforce diversity efforts, particularly in administrative leadership roles.

To tackle these important issues, in this dissertation I examine the healthcare administrative workforce at three career stages: early, mid, and late career. Given that less attention has been given to understanding how race and racism has been historically and structurally built into healthcare organizations and the implications this has on the healthcare administrative workforce, the goals of this dissertation are to identify how this oversight affects: 1) the recruitment and retention of a diverse administrative workforce, 2) the development of effective diversity, equity, and inclusion (DEI) and health equity strategies, and 3) the training and development of early career professionals.

Advancing health equity, improving diversity in healthcare leadership, and addressing health disparities in the United States for historically marginalized populations is a multifaceted undertaking that demands a deep understanding of various critical factors throughout the career trajectory of healthcare professionals. Key to this understanding is recognizing how systemic issues related to race and racism are embedded in healthcare organizations and how these issues affect different career stages, from entry-level positions to executive roles. Addressing these challenges involves a comprehensive examination of recruitment practices, professional development pathways, and organizational policies that either facilitate or hinder diversity and inclusion.

A crucial aspect of this examination is the integration of DEI and health equity principles into administrative fellowship programs, which are often a primary avenue for career advancement in healthcare leadership. Understanding the impact of racialized and gendered expectations in job advertisements and fellowship practices is essential for developing more equitable professional development opportunities. Additionally, analyzing the influence of occupational roles and hierarchical positions, particularly in middle management, provides insights into how these factors affect the

implementation and perceived success of health equity initiatives within healthcare organizations. Lastly, investigating how organizations incorporate race and racism into their strategic goal setting reveals its impact on the effectiveness of Black Chief Health Equity Officers and Chief DEI Officers in fulfilling their roles.

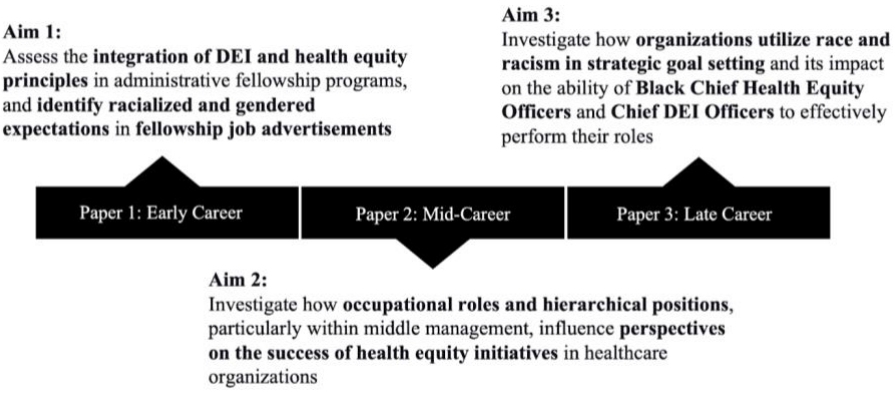
In the dissertation, my primary aims are to:

1. Assess the integration of DEI and health equity principles in administrative fellowship programs, and identify racialized and gendered expectations in fellowship job advertisements;

2. Investigate how occupational roles and hierarchical positions, particularly within middle management, influence perspectives on the success of health equity initiatives in healthcare organizations, and;

3. Investigate how organizations utilize race and racism in strategic goal setting and its impact on the ability of Black Chief Health Equity Officers and Chief DEI Officers to effectively perform their roles

Figure 1 Dissertation Aims



Navigating the Intersection of DEI and Health Equity in Healthcare Leadership Research: Conceptual Differences and Common Goals

Diversity, equity, and inclusion (DEI) refer to a set of values and practices that aim to create a workplace, educational setting, or other environment where everyone feels valued, respected, and included, regardless of their race, ethnicity, gender, sexual orientation, religion, or other identity factors. The American Association of Medical Colleges (AAMC), for example, defines DEI as a practice that actively promotes and values diversity, eliminates discrimination and bias, and creates an inclusive environment that allows all individuals to thrive (AAMC, 2019).

Health equity, on the other hand, refers to the idea that everyone has a fair and just opportunity to be as healthy as possible (Robert Wood Johnson Foundation, 2023). This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care (Robert Wood Johnson Foundation., 2023).

While DEI and health equity share common goals and there is synergy between the two fields, they are not interchangeable concepts. In my dissertation, I use both terms strategically to emphasize the importance of diversifying healthcare leadership. For example, I might use DEI language to talk about creating an inclusive and supportive workplace culture where all individuals feel valued and respected, regardless of their identity factors. I will draw on literature that demonstrates the benefits of diverse leadership teams, such as a study by Gomez and Bernet (2019), that found that hospitals with more diverse leadership teams had better financial performance and patient satisfaction scores. I may also point to several studies that demonstrate the negative impact of diverse leadership teams, such as a study by Jackson, Joshi and Erhardt (2003), that found diversity may result in social divisions and negative intra-group processes, such as dysfunctional forms of conflict.

At the same time, I will also use health equity language to talk about the need to address systemic barriers that prevent underrepresented groups from entering and advancing in healthcare leadership roles. For example, I will draw on organizational management and public health literature that discuss strategies for promoting health equity, such as mentoring and professional development programs that support the advancement of underrepresented groups in healthcare leadership.

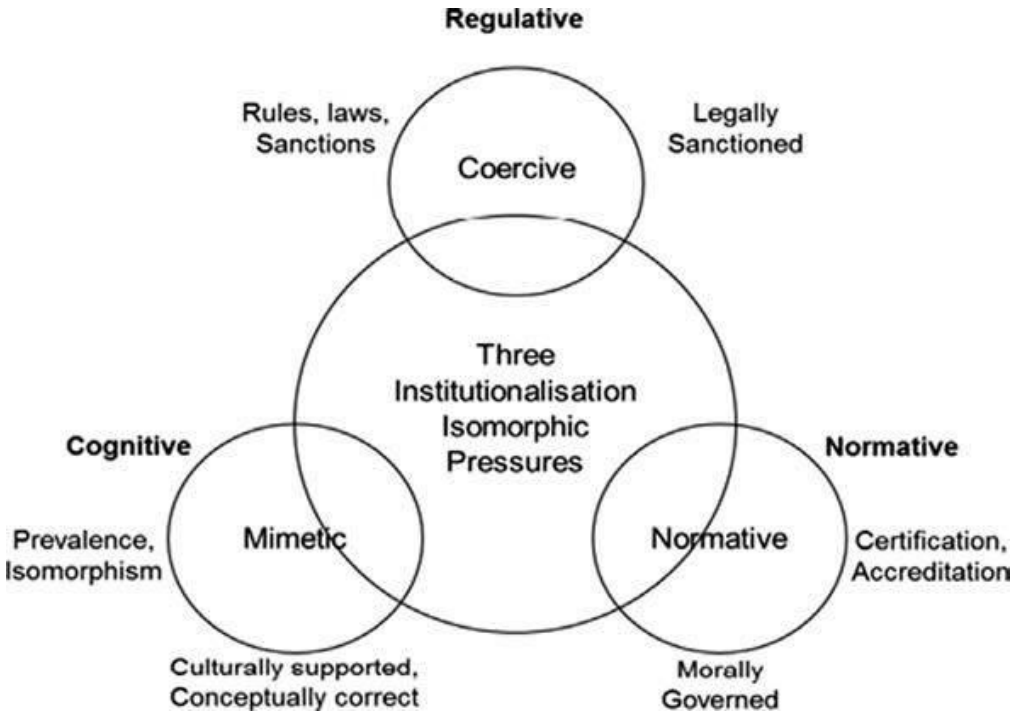
By using both DEI and health equity language in my dissertation proposal, I can underscore the importance of creating a more diverse and equitable healthcare leadership landscape, while also acknowledging the complex social, economic, and systemic factors that impact access to leadership roles. For example, to distinguish efforts aimed at workforce diversity from those targeting equity in patient care delivery and health of communities, I will build upon Dr. Lisa Cooper and her colleagues recommendations (2021) for healthcare organizations:

1. Develop and disseminate clear and distinct institutional definitions of (1) workforce diversity, inclusion, and equity efforts and (2) efforts to advance health and health care equity and community or population health
2. Highlight both efforts as core to the mission of the institution; recognize and reward excellence in both domains
3. Clarify that leaders and programs within the institution are accountable for achieving both goals
4. Appoint people with specific expertise, leadership skills, and demonstrated values and commitment to the work, not just identities that align with the target groups

1.2 Theory and Conceptual Frameworks

Institutional theory is a useful framework for understanding how healthcare organizations approach diversity and inclusion initiatives within their workforce, including leadership teams. Institutional theory posits that organizations are influenced by external social and cultural norms and pressures that shape their behavior, practices, and structures. Three types of isomorphism - coercive, mimetic, and normative - are mechanisms through which organizations conform to external norms and expectations (see Figure 2).

Figure 2 DiMaggio and Powell's Institutional Theory - Isomorphic Pressures & Org Fields



Adapted from: DiMaggio, P., & Powell, W. (1983). The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. American Sociological Review, 48(2), 147–160; Adapted by: Toinpre, O., Mackee, J., & Gajendran, T. (2018). A Framework for Understanding the Influence of Isomorphic Pressures on Governance of Disaster Risks. Procedia Engineering, 212, 173–180. https://doi.org/10.1016/j.proeng.2018.01.023

Coercive isomorphism refers to the use of formal and informal sanctions to force organizations to adopt certain practices or behaviors. This type of isomorphism can be seen in the case of healthcare organizations being pressured to increase diversity in their workforce or leadership teams to avoid legal sanctions or reputational harm. Mimetic isomorphism, on the other hand, is when organizations mimic the practices and structures of other organizations that they perceive as successful. In healthcare, this can manifest in organizations adopting diversity and inclusion policies or hiring diversity officers because they see it as best practice or to remain competitive with other healthcare organizations. Finally, normative isomorphism refers to organizations conforming to the social norms and values of the larger community or industry. For healthcare organizations, this can mean adopting diversity and inclusion initiatives as a response to societal expectations and demands for social justice.

Organizational legitimacy is another key concept in institutional theory that relates to how organizations can and maintain legitimacy in the eyes of external stakeholders (Dowling & Pfeffer, 1975). Legitimacy is important for organizations because it confers social approval, resources, and access to decision-

making power. In healthcare, organizations may seek to gain legitimacy by promoting diversity and inclusion initiatives, or health equity initiatives to demonstrate their commitment to social responsibility and to improve their public image. Diversity statements are another example of how organizations might seek to maintain legitimacy. However, there is a gap in knowledge regarding the type of legitimacy associated with good diversity policies (Singh and Point, 2009). Singh and Point (2009), assert that within the diversity field, there is an assumption that having diversity statements and policies will attract legitimacy without specifying how or what type.

The rush by healthcare organizations to hire chief diversity and chief health equity officers after the "racial reckoning" following the murder of George Floyd and the Black Lives Matter movement can be seen as an example of both coercive and normative isomorphism, as well as an effort to gain organizational legitimacy. The social and political pressure for healthcare organizations to address systemic racism and health disparities, as well as the desire to remain competitive in a changing healthcare landscape, has led many organizations to adopt DEI and health equity initiatives as a way to demonstrate their commitment to social responsibility and to gain legitimacy in the eyes of external stakeholders.

Overall, the intentional theory provides a useful lens for understanding the factors that shape healthcare organizations' approach to diversity and inclusion initiatives, including the pressure to conform to external norms and expectations, the importance of organizational legitimacy, and the role of isomorphism in shaping organizational behavior and practices.

Theory of Racialized Organizations

While I acknowledge institutional theory throughout my dissertation, the theoretical frame that my dissertation is grounded in is the Theory of Racialized Organizations. For years, scholars of race and scholars of organizational theory have criticized the absence of a structural theory on race and organizations. Acker's (1990) and Nkomo's (1992) works called for scholars to move beyond contextualizing race as a demographic characteristic. Bonilla-Silva (1997) and Wooten (2019) have emphasized the need for a theory that engages with both the sociology of race and organizational theory. Wooten and Coulette (2017) specifically argued that organizations can have an "identity," that allows

them to be racialized in much the same way that people are. As racialized spaces, organizational beliefs, rituals, norms, and language can serve to reproduce inequalities.

While Wooten and Coulette (2017) highlight the ways organizations can develop a racial identity, Victor Ray (2019) focuses on highlighting the ways in which organizations are not race neutral. Ray's theory posits that organizations are not meritocracies, but rather long-standing social structures designed and managed to prioritize whiteness. By seeing organizations as racial structures, we can pay attention to fundamental sociological and organizational questions about power, structure, and agency. With these different approaches to racialized organizations, it is possible to think about the ways in which healthcare institutions may be racialized (Wingfield & Chavez, 2020). Healthcare systems have a long history of embedded assumptions about race, health, and medicine that reproduce racial inequalities within them (Hoberman, 2012). Further, healthcare systems may take on a racialized identity as "white spaces" through cultural and normative practices, such as stereotyping Black patients as noncompliant or downplaying their accounts of pain (Wingfield & Chavez, 2017).

Organizational structure can also reinforce how these facilities function as white spaces. For example, jobs at different levels require varying responsibilities and qualifications. Internal processes such as credentialing help maintain racial segregation across the organizational hierarchy. As Feagin and Bennefield explain, health system administrations and decision-makers are disproportionately white and exercise considerable power over the health of racially minoritized populations (Feagin and Bennefield, 2014). Given what we know about racialized organizations and the lack of literature looking at healthcare organizations, in particular, as racialized spaces, I hope to advance the theory of racialized organizations in my dissertation by examining how organizational mechanisms may help or hinder our efforts towards advancing health equity and DEI work and diversifying the administrative workforce.

Dissertation Roadmap

This dissertation uses a qualitative approach to examine the healthcare administrative workforce at three career stages: early, mid, and late career. **In Chapter 2,** I evaluate the integration of DEI and

health equity principles in healthcare administrative fellowship programs and analyze job advertisements for racial and gender biases. To my knowledge, this is the first study that examines healthcare administrative fellowship job advertisements for either DEI or health equity prioritization, as well as explore if gendered or racialized expectations are present in the job ads. **In Chapter 3,** I paper explores how middle management roles and hierarchical positions affect perceptions of organizational progress toward advancing health equity. By looking at the experiences of middle management, this study can identify whether organizational role or hierarchical positioning has an influence on DEI or health equity related organizational progress. **In Chapter 4,** I investigate the role of race and racism in strategic goal setting and its impact on Black Chief DEI and Health Equity Officers. Through in-depth interviews with Black executive leaders, I can understand how they conceptualize and make decisions about DEI and Health Equity within their organization. This analysis provides understanding of how healthcare organizations utilize Black leaders in executive positions for strategic purposes. It includes key insights on how Chief DEI and Chief Health Equity Officers are resourced and supported in their roles.

In the final chapter, I summarize the findings of the dissertation and reflect on the implications for administrative workforce diversity in this country and the role DEI and health equity plays within organizations and the role employees play in actualizing those goals. I provide actionable recommendations, provide suggestions for extension of the theory of racialized organizations and include important topics for future research that will expand on the findings presented here.

Conclusion

This dissertation highlights the critical need to recruit and retain diverse administrative talent and dismantle racist policies and procedures within healthcare organizations. Such changes are essential for improving employee experiences—particularly for people of color—and addressing racial disparities in health outcomes. It also serves as a call to action during a politically charged period when efforts to undermine and erase DEI and health equity initiatives are intensifying in the United States.

References

ACKER, J. (1990). HIERARCHIES, JOBS, BODIES: A Theory of Gendered Organizations. *Gender & Society*, *4*(2), 139–158. https://doi.org/10.1177/089124390004002002

Alang, S., McAlpine, D., McCreedy, E., & Hardeman, R. (2017). Police Brutality and Black Health: Setting the Agenda for Public Health Scholars. *American Journal of Public Health*, *107*(5), 662–665. https://doi.org/10.2105/AJPH.2017.303691

Betancourt, J. R., & Maina, A. W. (2004). The Institute of Medicine report "Unequal Treatment": Implications for academic health centers. *The Mount Sinai Journal of Medicine, New York*, *71*(5), 314–321.

Bharmal, N., Derose, K. P., Felician, M., & Weden, M. M. (n.d.). *Understanding the Upstream Social Determinants of Health*.

Bleich, S. N., Findling, M. G., Casey, L. S., Blendon, R. J., Benson, J. M., SteelFisher, G. K., Sayde, J. M., & Miller, C. (2019). Discrimination in the United States: Experiences of black Americans. *Health Services Research*, *54*(S2), 1399–1408. https://doi.org/10.1111/1475-6773.13220

Bonilla-Silva, E. (1997). Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review*, *62*(3), 465–480. https://doi.org/10.2307/2657316

Braveman, P. (2014). What Are Health Disparities and Health Equity? We Need to Be Clear. *Public Health Reports*, *129*(Suppl 2), 5–8.

Braveman, P., Arkin, E., Orleans, T., Proctor, D., & Plough, A. (2017). *What is Health Equity?* [Robert Wood Johnson Foundation]. https://www.rwjf.org/en/insights/our-research/2017/05/what-is-health-equity-.html

Bureau, U. C. (2019). *National Population by Characteristics: 2010-2019*. Census.Gov. https://www.census.gov/data/tables/time-series/demo/popest/2010s-national-detail.html

Creary, S. J., Rothbard, N., & Scruggs, J. (2021). *Improving Workplace Culture Through Evidence-Based Diversity, Equity and Inclusion Practices*. OSF. https://doi.org/10.31234/osf.io/8zgt9

Crews, D. C., Collins, C. A., & Cooper, L. A. (2021). Distinguishing Workforce Diversity From Health Equity Efforts in Medicine. *JAMA Health Forum*, *2*(12), e214820. https://doi.org/10.1001/jamahealthforum.2021.4820

Dotson, E., Bonam, C., & Jagers, J. (2017). *Redefining Race as a Process: Implications for Healthcare Leadership*.

Dotson, E., & Nuru-Jeter, A. (2012). Setting the stage for a business case for leadership diversity in healthcare: History, research, and leverage. *Journal of Healthcare Management / American College of Healthcare Executives*, *57*(1), 35–44; discussion 45-46.

Ely, R. J., & Thomas, D. A. (2001). *Cultural Diversity at Work: The Effects of Diversity Perspectives on Work Group Processes and Outcomes*. https://journals.sagepub.com/doi/10.2307/2667087

Equity, Diversity, & Inclusion. (n.d.). AAMC. Retrieved August 2, 2024, from https://www.aamc.org/about-us/equity-diversity-inclusion

Feagin, J., & Bennefield, Z. (2014). Systemic racism and U.S. health care. *Social Science & Medicine (1982)*, *103*, 7–14. https://doi.org/10.1016/j.socscimed.2013.09.006

Frey, W. (n.d.). *The nation is diversifying even faster than predicted, according to new census data*. Brookings. Retrieved August 1, 2024, from https://www.brookings.edu/articles/new-census-data-shows-the-nation-is-diversifying-even-faster-than-predicted/

Goldstein, D., Manveer, G., & Williams, M. (2022). *How to set your chief diversity officer up for success*. https://www.mckinsey.com/capabilities/people-and-organizational-performance/our-insights/unlocking-the-potential-of-chief-diversity-officers

Gomez, L. E., & Bernet, P. (2019). Diversity improves performance and outcomes. *Journal of the National Medical Association*, *111*(4), 383–392. https://doi.org/10.1016/j.jnma.2019.01.006

Huang, K., Tapia, A., & Polonski, A. (2024). *Your Chief Diversity Officer Is Likely Leaving*. Retrieved August 1, 2024, from https://www.kornferry.com/insights/this-week-in-leadership/your-chief-diversity-officer-is-likely-leaving

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003a). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK220358/

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003b). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK220358/

Jackson, C. S., & Garcia, N. (2014). *Addressing Health and Health-Care Disparities: The Role of a Diverse Workforce and the Social Determinants of Health*. https://journals-sagepub-com.proxy.lib.umich.edu/doi/10.1177/00333549141291S211

Jackson, S. E., Joshi, A., & Erhardt, N. L. (2003). Recent Research on Team and Organizational Diversity: SWOT Analysis and Implications. *Journal of Management*, *29*(6), 801–830. https://doi.org/10.1016/S0149-2063(03)00080-1

Johnson, S. (2024). *In Health Care Boardrooms, Diversity Still Short of Demand*. US News & World Report. //www.usnews.com/news/health-news/articles/2024-03-04/report-more-diversity-needed-among-health-care-board-members

Laveist, T. A., & Nuru-Jeter, A. (2002). Is doctor-patient race concordance associated with greater satisfaction with care? *Journal of Health and Social Behavior*, *43*(3), 296–306.

Lopez, L., III, Hart, L. H., III, & Katz, M. H. (2021). Racial and Ethnic Health Disparities Related to COVID-19. *JAMA*, *325*(8), 719–720. https://doi.org/10.1001/jama.2020.26443

Mitra, M., Long-Bellil, L., Moura, I., Miles, A., & Kaye, H. S. (2022). Advancing Health Equity And Reducing Health Disparities For People With Disabilities In The United States. *Health Affairs*, *41*(10), 1379–1386. https://doi.org/10.1377/hlthaff.2022.00499

Morris Devin B., Gruppuso Philip A., McGee Heather A., Murillo Anarina L., Grover Atul, & Adashi Eli Y. (2021). Diversity of the National Medical Student Body—Four Decades of Inequities. *New England Journal of Medicine*, *384*(17), 1661–1668. https://doi.org/10.1056/NEJMsr2028487

National Academies of Sciences, E., Division, H. and M., Practice, B. on P. H. and P. H., States, C. on C.-B. S. to P. H. E. in the U., Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). The Root Causes of Health Inequity. In *Communities in Action: Pathways to Health Equity*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK425845/

Nkomo, S. M. (1992a). The emperor has no clothes: Rewriting "race in organizations." *The Academy of Management Review*, *17*(3), 487–513. https://doi.org/10.2307/258720

Nkomo, S. M. (1992b). The Emperor Has No Clothes: Rewriting "Race in Organizations." *The Academy of Management Review*, *17*(3), 487–513. https://doi.org/10.2307/258720

Organizational Legitimacy: Social Values and Organizational Behavior—John Dowling, Jeffrey Pfeffer, 1975. (n.d.). Retrieved August 2, 2024, from https://journals.sagepub.com/doi/10.2307/1388226

Palmer, R., Ismond, D., Rodriquez, E., & Kaufman, J. (2019). Social Determinants of Health: Future Directions for Health Disparities Research. *American Journal of Public Health*, *109*, S70–S71. https://doi.org/10.2105/AJPH.2019.304964

Pittman, P., Chen, C., Erikson, C., Salsberg, E., Luo, Q., Vichare, A., Batra, S., & Burke, G. (2021). Health Workforce for Health Equity. *Medical Care*, *59*, S405. https://doi.org/10.1097/MLR.0000000000001609

Ray, V. (n.d.). *Why So Many Organizations Stay White*. Retrieved August 1, 2024, from https://hbr.org/2019/11/why-so-many-organizations-stay-white

Ray, V. (2019). A Theory of Racialized Organizations. *American Sociological Review*, *84*(1), 26–53. https://doi.org/10.1177/0003122418822335

Rubin-Miller, L., Alban, C., Artiga, S., & Published, S. S. (2020, September 16). COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data. *KFF*.

https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/

Saha, S., Komaromy, M., Koepsell, T. D., & Bindman, A. B. (1999). Patient-Physician Racial Concordance and the Perceived Quality and Use of Health Care. *Archives of Internal Medicine*, *159*(9), 997–1004. https://doi.org/10.1001/archinte.159.9.997

Sharp, S., Hixson, A., Stumpff, J., & Williamson, F. (2022). Understanding the Experiences of Black Women Medical Students and Residents: A Narrative Review. *Frontiers in Public Health*, *10*. https://doi.org/10.3389/fpubh.2022.879135

Shen, M. J., Peterson, E. B., Costas-Muñiz, R., Hernandez, M. H., Jewell, S. T., Matsoukas, K., & Bylund, C. L. (2018). The Effects of Race and Racial Concordance on Patient-Physician Communication: A Systematic Review of the Literature. *Journal of Racial and Ethnic Health Disparities*, *5*(1), 117–140. https://doi.org/10.1007/s40615-017-0350-4

Silver, J. K., Bean, A. C., Slocum, C., Poorman, J. A., Tenforde, A., Blauwet, C. A., Kirch, R. A., Parekh, R., Amonoo, H. L., Zafonte, R., & Osterbur, D. (2019a). Physician Workforce Disparities and Patient Care: A Narrative Review. *Health Equity*, *3*(1), 360–377. https://doi.org/10.1089/heq.2019.0040

Silver, J. K., Bean, A. C., Slocum, C., Poorman, J. A., Tenforde, A., Blauwet, C. A., Kirch, R. A., Parekh, R., Amonoo, H. L., Zafonte, R., & Osterbur, D. (2019b). Physician Workforce Disparities and Patient Care: A Narrative Review. *Health Equity*, *3*(1), 360–377. https://doi.org/10.1089/heq.2019.0040

Singh, V., & Point, S. (2009). Diversity statements for leveraging organizational legitimacy. *Management International / Gestiòn Internacional / International Management*, *13*(2), 23–34. https://doi.org/10.7202/029777ar

Snyder, C. R., Frogner, B. K., & Skillman, S. M. (2018). Facilitating Racial and Ethnic Diversity in the Health Workforce. *Journal of Allied Health*, *47*(1), 58–65.

Street, R. L., O'Malley, K. J., Cooper, L. A., & Haidet, P. (2008). Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity. *The Annals of Family Medicine*, *6*(3), 198–205. https://doi.org/10.1370/afm.821

Toinpre, O., Mackee, J., & Gajendran, T. (2018). A Framework for Understanding the Influence of Isomorphic Pressures on Governance of Disaster Risks. *Procedia Engineering*, *212*, 173–180. https://doi.org/10.1016/j.proeng.2018.01.023

Vasquez Reyes, M. (2020). The Disproportional Impact of COVID-19 on African Americans. *Health and Human Rights*, *22*(2), 299–307.

Vespa, J., Medina, L., & Armstrong, D. M. (n.d.). *Population Estimates and Projections*.

Wilbur, K., Snyder, C., Essary, A. C., Reddy, S., Will, K. K., & Mary Saxon. (2020). Developing Workforce Diversity in the Health Professions: A Social Justice Perspective. *Health Professions Education*, *6*(2), 222–229. https://doi.org/10.1016/j.hpe.2020.01.002

Wingfield, A. (2020). *The Disproportionate Impact of Covid-19 on Black Health Care Workers in the U.S.* https://hbr.org/2020/05/the-disproportionate-impact-of-covid-19-on-black-health-care-workers-in-the-u-s

Wingfield, A. H., & Chavez, K. (2020). Getting in, getting hired, getting sideways looks: Organizational hierarchy and perceptions of racial discrimination. *American Sociological Review*, *85*(1), 31–57. https://doi.org/10.1177/0003122419894335

Woodruff, J. N., McDade, W. A., & Nakae, S. (2022). *COVID-19 Has Exacerbated Inequities That Hamper Physician Workforce Diversification*. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797556

Wooten, M. (2019). *Race, Organizations, and the Organizing Process|eBook*. https://www.barnesandnoble.com/w/race-organizations-and-the-organizing-process-melissa-e-wooten/1130059512

Wooten, M., & Couloute, L. (n.d.). *The production of racial inequality within and among organizations*. Retrieved August 2, 2024, from

https://compass.onlinelibrary.wiley.com/doi/abs/10.1111/soc4.12446?casa_token=wjnYJfERDPgAAAAA:iQ2cP2wDppMDo3GpXCJ_lLvqWHuKWTcHGdflV43pNHv8XyxRfCqp0T2NPJD381mlIfxRzOaW-tkd4I0

Yearby, R., Clark, B., & Figueroa, J. F. (2022). Structural Racism In Historical And Modern US Health Care Policy. *Health Affairs*, *41*(2), 187–194. https://doi.org/10.1377/hlthaff.2021.01466

Chapter 2 Racialized Expectations in Healthcare Administrative Fellowship Advertisements: What are the Implications for Diversifying Leadership Teams?

2.1 Background

Healthcare administrative fellowships have a storied history, dating back over four decades. Notably, the Massachusetts General Hospital (MGH) Administrative Fellowship, founded in 1973, holds the distinction of being the oldest postgraduate healthcare management fellowship program in the nation (Paciello, 2014). While these fellowships have evolved alongside the growing complexities of hospitals and healthcare delivery, their fundamental purpose remains unchanged: to provide master's degree graduates with practical experience that equips them for success in healthcare executive roles (Robbins, Graham, Garman, Smith, & Simms, 2022). The establishment of the American College of Healthcare Executives (ACHE) has played a pivotal role in elevating the prominence of postgraduate healthcare administrative fellowships, exemplified by programs like MGH. ACHE serves as a platform for hospitals nationwide to showcase their fellowship opportunities to potential candidates. Furthermore, ACHE extends support to hospitals in the creation of fellowship programs, offering guidance ranging from program design to recruitment and onboarding (ACHE, 2023)

The landscape of healthcare administrative fellowships has burgeoned over time, focusing on providing hands-on experiences and fostering future leaders in healthcare administration. Presently, more than 500 ACHE-accredited fellowships exist within hospitals in the United States, in addition to non-accredited programs (ACHE, 2023). These fellowships, spanning one to two years, provide fellows with exposure to hospital operations and healthcare systems, often working closely with high-level executives (American College for Healthcare Executives, 2022). The broader health administration research literature has explored the significance of administrative fellowships, predominantly focusing on overall

fellowship program experiences, fellows' assessments of program value, and rationale for participation (Lomperis, Howard, & Lemak, 2014; Hilsenrath, 2012; Haddock, McClean, & Chapman, 2002; Cronin, 2014; Paciello, 2014, Robbins et al., 2020; Garman et al., 2014). While more recent literature have begun to focus on the value of administrative fellowships in the era of COVID-19, the future of health administration education, diversity, equity and inclusion (DEI) in healthcare management education, and the gender gap in healthcare leadership (Robbins et al., 2020, Enard et al., 2017, Dreachslin et al., 2017, Lyness et al., 2018).

As entry points for early careerists with potential for senior executive positions, fellowships allow individuals to develop critical skills through projects and rotations, facilitating a smoother transition into healthcare management roles (Robbins et al., 2021). Upon completion of their fellowship training, fellows would have been exposed to various management domains, including operations, strategy, quality improvement, and supply chain functions. However, the integration of health equity, diversity, and inclusion (DEI) principles within administrative fellowship training presents a concerning gap. This is especially true as recent scholarship suggests that administrative fellowships may even widen, rather than alleviate gender disparities in healthcare leadership (Robbins, Graham, Garman, Smith, & Simms, 2022; Lyness & Grotto, 2018). Yet, we lack similarly critical and in-depth literature on fellowship programs and their influence on advancing health equity and promoting diversity in the upcoming generation of healthcare leaders. In particular, there is a significant research gap regarding whether fellowship programs contribute to racial and ethnic disparities in healthcare leadership, as well as their efficacy in developing diversity, health equity, and inclusion (DEI) and health equity skills among fellows before they transition into management roles.

To advance health equity, we must cultivate a public health workforce equipped with the core competencies and skill sets to design health policy, public health programs, and clinical interventions that reduce and eliminate health disparities (Institute of Medicine, 2003; Mitchell & Lassiter, 2006). However, a recent analysis of Master of Public Health (MPH) programs in health policy and management (HPM) uncovered a troubling reality – while 68% of HPM tracks offer elective courses in health equity and

disparities, only 12% of health policy and management (HPM) tracks require students to engage with these topics (Gonzales et al., 2018). The implications intensify as hospitals with fellowship programs frequently recruit fellows from HPM programs, likely with the expectation that prospective applicants have some grounding in a wide array of healthcare management and policy issues, including health equity and its implications for the provision of high-quality health care.

Considering the variability in health equity, diversity, and inclusion exposure across applicants, if fellowship programs fail to fully integrate health equity, diversity, and inclusion principles into their management training, there's a consequential risk that future health policy makers and administrators – might lack a foundational understanding of health equity principles and goals, which hold national significance. The resulting gap in understanding could undermine the implementation of policies and initiatives aimed at advancing health equity and promoting diversity, impacting not only the workforce but also the well-being of historically marginalized communities. Moreover, fellowship advertisements often serve as the initial point of contact for prospective applicants seeking insights into professional development opportunities. While these candidates might have reviewed an organization's broader mission and value statement, the fellowship description remains pivotal in guiding their decisions about whether the fellowship aligns with their professional aspirations. If these descriptions fall short in emphasizing the importance of diversity, equity, and inclusion (DEI) and health equity, hospitals may inadvertently deter potential applicants who value these principles, diverting them toward opportunities that place greater emphasis on such topics.

Job Advertisements as an Institutional-Level Contributor to Leadership Diversity Inequity

Beyond potentially dissuading applicants, job advertisements may subtly perpetuate racial oppression through terms like “cultural fit” and “professional demeanor.” These seemingly innocuous phrases often reflect entrenched racialized expectations within society and the job market. They can inadvertently exclude qualified candidates from underrepresented backgrounds by emphasizing subjective criteria that may align more closely with dominant cultural norms.

For instance, terms like “cultural fit” can mask discriminatory hiring practices that favor candidates who conform to dominant cultural and organizational norms, perpetuating homogeneity in leadership teams. Similarly, expectations of “professional demeanor” may unfairly disadvantage individuals from marginalized communities, who may express professionalism differently due to cultural or socioeconomic factors. Drawing from Chandra Ford's public health critical race praxis (2010), which underscores the ordinariness of racism in society, it is plausible that racialized expectations subtly permeate the language and qualifications of job advertisements. By interrogating the language and qualifications presented in fellowship ads, I aim to uncover and challenge racialized norms that perpetuate inequities in leadership development recruitment.

Overview of the Present Research

To gain a comprehensive understanding of organizational and fellowship priorities pertaining to diversity, equity, and inclusion (DEI) and health equity, we must explore available fellowship opportunities and assess if there has been a stronger focus on these areas over time. Currently, this aspect remains underexplored, representing a gap in our understanding of how healthcare organizations convey their commitment to these principles.

To our knowledge, the proposed study provides the first content assessment of American College of Healthcare Executives (ACHE) accredited administrative fellowship program descriptions in the United States. This study serves a dual purpose: 1) Determine the availability and types of fellowship programs and assess the extent of health equity, diversity, and inclusion exposure within healthcare administrative fellowships from 2020 to 2023; and 2) Explore how the language in healthcare administrative fellowships might demonstrate racialized expectations or preferences.

I ask the following research questions to achieve these study objectives:

- What are the availability and types of administrative fellowship programs offered between 2020 and 2023, and is there a stronger focus on health equity and DEI over time?

- How do the language and qualifications presented in administrative fellowship ads contribute to and reflect potential racialized expectations or preferences? What are the implications for diversifying leadership teams in healthcare?

The goal of the first research question is to provide a foundational understanding of what is being offered in the professional development space for healthcare administrative professionals. The second goal is to understand how the publication of job advertisements, which include racialized expectations and language, potentially contribute to the perpetuation of racial disparity in healthcare leadership teams.

2.2 Theoretical Framing

The theory of racialized organizations (2019), developed by Victor Ray, provides a lens for understanding how racial dynamics are deeply embedded within organizational structures, processes, and practices. This theory posits that organizations are not neutral entities; rather, they are racialized spaces that reflect and perpetuate existing racial hierarchies and inequalities. Organizations distribute resources in ways that can constrain or enable individual agency and shape one's future. These resources include tangible assets like financial support and less tangible factors such as mentorship and professional development opportunities (Taiko, Ray, & South, 2022). The theory argues that Whiteness functions as a credential, offering greater access to leadership and the benefit of uneven application of formal rules and policies. By focusing on the mechanisms through which organizations embed and sustain these hierarchies, the theory provides a robust framework for examining the racialized dimensions of administrative fellowship programs in healthcare. This perspective is particularly relevant to my research, which investigates the availability and types of fellowship programs from 2020 to 2023, their focus on health equity and DEI, and how the language and qualifications in fellowship ads reflect and perpetuate racialized expectations.

Applying the theory of racialized organizations allows for critical analysis of how racial inequalities are maintained through seemingly neutral organizational processes, such as recruitment and

job advertisements. Fellowship programs, which are pivotal in shaping the future leadership of healthcare organizations, often use language and set qualifications that can inadvertently perpetuate racial biases. By embedding racialized expectations within job advertisements and criteria, these programs can contribute to the underrepresentation of marginalized racial groups in future leadership positions. Other research in this space has considered the theory of racialized organizations in relationship to medical schools, medical student experiences, and educational outcomes. They found that discriminatory processes of racial sorting do not end upon medical school admission (Taiko, Ray, & South, 2022). Instead, during medical school, racialized processes that impact careers are classified into broad overlapping categories including learning climate and culture, clinical experience, opportunities, residency application process, and preclinical experience (Taiko, Ray, & South, 2022). Yet, a similar analysis of discriminatory processes in healthcare administrative fellowships have largely been ignored, and whether or not the construction of the job ads (arguably a racial structure) may affect prospective students' perspectives and trajectories, including intentional exposure to DEI and health equity training.

Institutional theory provides additional insight by examining how organizations adopt similar practices to achieve legitimacy and conformity within their industry (DiMaggio & Powell, 2000) (see Chapter 1). This framework introduces the concept of isomorphism—normative, mimetic, and coercive—which helps explain how organizations align their practices with industry norms and peer institutions. Normative isomorphism pertains to professional norms and values, while mimetic isomorphism involves imitating practices of successful or prestigious organizations. Coercive isomorphism reflects pressures from external forces, such as regulations or market demands. This theory, in conjunction with the theory of racialized organizations, helps explain why organizations may integrate DEI and health equity into fellowship programs, as they seek to align with industry standards and enhance their legitimacy.

However, this theory also reveals why changes might be inconsistent or superficial, as organizations may face resistance to altering entrenched practices despite societal pressures.By

incorporating both the theory of racialized organizations and institutional theory, this study offers a comprehensive understanding of how organizations respond to societal shifts and work to advance DEI and health equity in healthcare leadership. These frameworks together help address the research questions by analyzing the representation and impact of DEI and health equity initiatives in fellowship programs, and how these initiatives intersect with organizational norms and practices.

2.3 Objective

This study serves a dual purpose: 1) Determine the availability and types of fellowship programs and assess the extent of health equity, diversity, and inclusion exposure within healthcare administrative fellowships from 2020 to 2023; and 2) Explore how the language in healthcare administrative fellowships might demonstrate racialized expectations or preferences.

I ask the following research questions to achieve these study objectives:

- What are the availability and types of administrative fellowship programs offered between 2020 and 2023, and is there a stronger focus on health equity and DEI over time?
- How do the language and qualifications presented in administrative fellowship ads contribute to and reflect potential racialized expectations or preferences? What are the implications for diversifying leadership teams in healthcare?

2.4 Study Design and Methodology

Availability and Type of Fellowship Programs

To comprehensively assess healthcare administrative fellowship descriptions, a content analysis was conducted on publicly available fellowship data from the American College of Healthcare Executives (ACHE) fellowship directory. Content analysis methods aim to quantitatively analyze qualitative data, identifying patterns and trends in the frequency of specific topics mentioned within a qualitative data

corpus (Neuendorf, 2019). This method has been successfully applied to issues concerning equity, diversity, and inclusion (Rosa et al., 2016). The ACHE fellowship directory serves the purpose of providing a list of available postgraduate administrative fellowships to students and early careerists while allowing sponsoring organizations to promote and increase visibility for their programs. The ACHE fellowship directory does not encompass a comprehensive list of all available fellowships nationwide, but is one of the most widely used platforms by hospitals who offer fellowship programs across the country.

The decision to analyze administrative fellowship descriptions was based on their ability to offer valuable insights into how organizations present themselves, articulate the benefits they offer prospective applicants, and outline the competencies they anticipate fellows to acquire throughout the program. As emphasized by Kim and Angnakoon (2016), in their methodological evaluation of job ads research, the analysis of job advertisements has long been recognized as a reliable method to highlight emerging trends in the job market and potentially forecast future trends.

To select administrative fellowship advertisements for the analysis, two fundamental aspects of a fellowship program were considered: providing management training within a hospital, health system, or healthcare organization, and commencing the fellowship program post-graduation with a specified fellowship participation period, typically ranging from one to two years. Job descriptions meeting these basic requirements were included in the study's analysis. Duplicate fellowship listings were excluded from the analysis, and when possible, the full online versions of job postings were examined if referenced in the shorter fellowship descriptions.

Coding

To ensure the practical applicability of the codebook, a preliminary sample of ten administrative fellowship descriptions was selected for analysis. The initial sampling aided in refinding the codebook before proceeding with the comprehensive analysis of fellowship programs.The analysis was conducted using the MAXQDA software. The coding process aimed to extract specific information from each fellowship posting, including information regarding fellowship design, management exposure areas, and organizational features.

The study identified three dimensions of fellowship design: (1) structured and single-focused functional programs, characterized by predetermined program structure in one focus area; (2) structured and multi-functional fellowships, characterized by a set structure with exposure to multiple management focus areas; and (3) customized and multi-functional fellowships, characterized by exposure to multiple focus areas and tailored to individual applicants' interests. Multi-functional programs (#2 and #3) have fellows rotate across the different functional areas and are thus also termed "rotational" programs. Among the multi-functional options, including executive track, strategy, and clinical, there were some opportunities for management exposure in DEI and/or health equity. If programs included a management exposure area in DEI and/or health equity, coding was applied.

Single-focused areas pertained to specialized domains within management, encompassing finance, operations, health equity or DEI, human resources, quality improvement, information technology and digital health, strategy, and supply chain. The "finance" code referred to programs emphasizing financial management skills. "Operations" represented fellowships tailored to operational management insights, while "health equity or DEI" indicated programs with a pronounced emphasis on diversity, equity, and inclusion or health equity. "Human resources" codes were assigned to programs offering exposure to HR management, and "quality improvement" designated programs focusing on methodologies and practices. Similarly, "information technology and digital health" codes applied to programs integrating IT and digital health management, while "strategy" denoted those centered on strategic management. Finally, "supply chain" referred to fellowships concentrating on supply chain and logistical aspects (see Appendix for operational definitions).

In contrast, multi-functional areas indicated rotations across diverse management domains, providing fellows with broad exposure to various management areas including multifunctional specialized rotation, executive track, operations, clinical experience, strategy & analytics, and multi-functional policy and advocacy. "Multi-functional specialized rotation" indicated rotations across varied functions including finance and human resources, while "multi-functional executive track" coded fellowships designed for executive leadership preparation. "multi-functional operations" in the multi-functional

context denoted rotations in operational management. "Multi-Functional clinical" referred to fellowships combining clinical exposure and management training, and "multi-Functional strategy" signified integration of strategic planning and data analytics in rotations. "Multi-functional policy and advocacy" represented exposure to policy and advocacy across multiple management functions (see Appendix for operational definitions).

Racialized Language in Fellowship Ads

In examining racialized language within healthcare administrative fellowship advertisements, this study employed a detailed coding process to identify and analyze specific terms and phrases that reflect racialized expectations. The coding aimed to uncover how language within fellowship ads might perpetuate racial biases or preferences, based on the framework of the theory of racialized organizations.

Racialized Expectations

To assess racialized expectations, the following codes were applied:

- **Preference Indicators:** This code captured language that explicitly or implicitly indicated a preference for certain racial or ethnic backgrounds. Phrases such as “preferred candidates from diverse backgrounds” or “culturally competent individuals” were scrutinized. These terms were analyzed for their potential to signal a preference or bias towards candidates of specific racial or ethnic groups.
- **Cultural Competence**: This code identified instances where ads emphasized the need for cultural competence or experience working with diverse populations. Terms like “experience with culturally diverse communities” or “ability to engage with various cultural groups” were examined to determine whether they suggested an expectation of racial competence that might disadvantage those not explicitly identified within these groups.

- **Implicit Bias Indicators:** This category included language that might subtly reinforce racial hierarchies or stereotypes. Phrases that implicitly suggested racial biases, such as “leadership potential” in contexts where racial assumptions might be made, were coded. This code aimed to reveal how language might reinforce existing racial hierarchies within the fellowship programs.

Gendered Language in Fellowship Ads

The analysis of gendered language in fellowship ads focused on identifying and understanding how language might reflect or perpetuate gender biases. This involved coding for various aspects of gendered language that could influence the inclusivity and attractiveness of fellowship programs to different genders.

Gendered Language Expectations

The analysis of gendered language in fellowship ads focused on identifying and understanding how language might reflect or perpetuate gender biases. This involved coding for various aspects of gendered language that could influence the inclusivity and attractiveness of fellowship programs to different genders.

Gendered Language

The job advertisements were also coded to assess gendered language related to the expectations for the types of work to be done and the characteristics that applicants should have for the role. For example,

- Language associated with traditional gendered characteristics of masculinity or femininity. Terms like “assertive leadership” or “strong management skills” may implicitly favor males over females based on stereotypical expectations.
- Language such as “competitive” or “driven” to describe the ideal applicant might influence the appeal of the fellowship to different genders.

- In contrast, gender-neutral terms like “qualified candidates” is an example of how language may signal a more inclusive workplace.

By applying these codes, the study explores how racialized expectations and gendered language are embedded in fellowship ads and how such language might impact the diversity of applicants. Coding for racialized expectations involved identifying language that either explicitly or implicitly suggested biases or preferences based on race or ethnicity. This included looking for terms that indicated racial preferences, emphasized cultural competence, or reinforced implicit racial biases. Coding for gendered language involved analyzing how fellowship ads might reflect or perpetuate gender biases through traditional gender roles or gender-specific descriptors. By identifying these patterns, the study provides insights into how language in fellowship ads can influence both racial and gender diversity within healthcare leadership programs.

2.5 Results

Health Administration Fellowship and Functional Areas

Healthcare administrative fellowship (HAF) programs changed across the years 2020 to 2023. Table 1 shows the number and type of functional areas in HAF programs during this period. The COVID-19 pandemic impact on HAFs is evident in the change in the number of HAFs offered, with 260 positions in 2020 offered by over 100 healthcare organizations (n=126 organizations) compared to only 160 positions in 2021 offered by only 79 organizations. The year 2022 saw a rebound to pre-COVID levels (124 organizations offering 249 positions), with a slight decline in number of organizations offering HAFs in 2023 (n=97), but similar numbers of positions (n= 220 in 2023).

In terms of non-rotational functional areas, the analysis revealed variations in the distribution of fellowship positions among different domains. Notably, the “Health Equity, Diversity, & Inclusion” category saw fluctuations, with 8 (3.1%) positions in 2020. There was a noticeable jump to 17 (10.6%) positions in 2021, aligning with the application year for Fall 2020 when various social movements were

happening in the United States. However, this commitment began to decline afterward, with 8 positions in 2022 and further to 5 (2.3%) positions in 2023 (see Table 1). Similarly, positions in the "Operations" category varied, with 7 (2.7%) positions in 2020, 4 (2.5%) in 2021, 16 (6.4%) in 2022, and 16 (7.3%) in 2023. The "Strategy & Analytics" category exhibited similar trends, with 3 (1.1%) positions in 2020, 1 (0.6%) in 2021, 6 (2.4%) in 2022, and 4 (1.8%) in 2023. Positions in the "Quality Improvement," "Human Resources," "Information Technology," "Finance," and "Supply Chain" categories also demonstrated variations over the years.

The analysis also considered rotational functional areas, categorized as "Multi-Functional" rotational areas. Some of these options, including “Multi-Functional Executive Track,” “Multi-Functional Strategy,” and “Multi-Functional Clinical,” offered management exposure areas in DEI and health equity for fellowship applicants. The "Multi-Functional Executive Track" category had 154 positions in total, distributed as 42 (17.3%) in 2020, 21 (13.1%) in 2021, 56 (22.5%) in 2022, and 35 (15.9%) in 2023. Similarly, the "Multi-Functional Strategy" and "Multi-Functional Clinical" categories demonstrated variations in the distribution of positions. Additionally, the "Multi-Functional Health Policy" category exhibited differences, with 5 (1.9%) positions in 2020, 1 (0.6%) in 2021, 4 (1.6%) in 2022, and 6 (2.7%) in 2023.

Table 1 Health Administration Fellowship Counts and Functional Area by Year

Table 1. Health Administration Fellowship Counts and Functional Areas by Year, 2020 to 2023

	All Years	2020	2021	2022	2023
Healthcare Organizations	426	126	79	124	97
No., Open Fellowship Positions	889	260	160	249	220
Single-Focus Functional Areas					
Health Equity, Diversity & Inclusion	38 (4.3%)	8 (3.1%)	17 (10.6%)	8 (3.2%)	5 (2.3%)
Operations	43 (4.8%)	7 (2.7%)	4 (2.5%)	16 (6.4%)	16 (7.3%)
Strategy & Analytics	14 (1.6%)	3 (1.1%)	1 (0.6%)	6 (2.4%)	4 (1.8%)
Quality Improvement	35 (3.9%)	4 (1.5%)	18 (11.2%)	3 (1.2%)	10 (4.5%)
Human Resources	6 (0.7%)	1 (0.4%)	2 (1.2%)	1 (0.4%)	2 (0.9%)
Information Technology	18 (2.0%)	8 (3.1%)	3 (1.9%)	3 (1.2%)	4 (1.8%)
Finance	17(1.9%)	5 (1.9%)	4 (2.5%)	6 (2.4%)	2 (0.9%)
Supply Chain	8 (0.9%)	3 (1.1%)	1 (0.6%)	4 (1.6%)	-
Multi- Functional Areas					
*Multi-Functional Executive Track	154 (17.3%)	42 (16.1%)	21 (13.1%)	56 (22.5%)	35 (15.9%)
*Multi-Functional Strategy	75 (8.4%)	23 (8.8%)	16 (10.0%)	15 (6.0%)	21(9.5%)
*Multi-Functional Clinical	85 (9.6%)	28 (10.8%)	18 (11.2%)	21 (8.4%)	18 (8.2%)
Multi-Functional Health Policy	16 (1.8%)	5 (1.9%)	1 (0.6%)	4 (1.6%)	6 (2.7%)
Unspecified					
Unspecified	27 (3.0%)	8 (3.1%)	1 (0.6%)	4 (1.6%)	14 (6.4%)

Source; American College of Healthcare Executives (ACHE) fellowship directory years 2020 to 2023
***Might include DEI or health equity rotation**

DEI/Health Equity and non-DEI/Health Equity Fellowships with Customized versus Structured Focus

The analysis revealed diverse dimensions of fellowship design within the administrative fellowship programs. The breakdown of fellowships based on their structured and customizable features, along with their focus on diversity, equity, and inclusion (DEI) and health equity (HE), provides valuable insights into the landscape of healthcare administrative training. Structured, multi-functional fellowships, offering exposure to multiple management areas, demonstrated a similar trend to the "Health Equity, Diversity, & Inclusion" category. Thirty-four (34)(3.8%) positions mandated that DEI and HE be

included in their management training, with the most programs requiring this in 2021 (19) (11.9%) and it has since declined to only 3 (1.4%) in 2023 (see Table 1).

Customized, multi-functional fellowships, providing tailored programs, showcased the highest number of DEI and HE-focused positions (52 positions, 5.8%). The years 2020 and 2021 exhibited the highest counts (12 (4.6%) and 20 (12.5%) positions, respectively), followed by a gradual decline in 2022 and 2023 (13 (5.2%) and 7 (3.2%) positions, respectively) (see Table 1). This suggests that a significant portion of fellowship programs incorporated collaborative approaches, promoting engagement and customization for fellows. However, the presence of customization raises concerns about the integration of DEI and health equity as integral components within the fellowship program. If DEI and health equity are not embedded as core elements and remain optional or dependent on fellows' interests, there is a risk that these important aspects may not receive the necessary attention and commitment they deserve, both in terms of fellows' professional development and the advancement of DEI and health equity within the healthcare organization.

Table 2 DEI/HE and non DEI/HE with Customized versus Structured by year

	All Years	**2020**	**2021**	**2022**	**2023**
Total	889	260	160	249	220
Structured, Single-Focus					
DEI/HE-focused	38 (4.3%)	8 (3.1%)	17 (10.6%)	8 (3.2%)	5 (2.3%)
Non-DEI/HE focused	141 (15.9%)	31 (11.9%)	33 (20.6%)	39 (15.7%)	38 (17.3%)
Structured, Multi-Functional					
DEI/HE-focused	34 (3.8%)	10 (3.8%)	19 (11.9%)	2 (0.8%)	3 (1.4%)
Non-DEI/HE focused	225 (25.3%)	67 (25.8%)	10 (6.3%)	52 (20.9%)	96 (43.6%)
Customized, Multi-Functional					
DEI/HE-focused	52 (5.8%)	12 (4.6%)	20 (12.5%)	13 (5.2%)	7 (3.2%)
Non-DEI/HE focused	372 (41.8%)	124 (46.7%)	60 (37.5%)	131 (52.6%)	57 (25.9%)
Unspecified					

Unspecified	27 (3.0%)	8 (3.0%)	1 (0.6%)	4 (1.6%)	14 (6.4%)

Note: DEI Diversity Equity Inclusion; HE Health Equity

Racialized and Gendered Expectations and Language in Fellowship Advertisements

Fellowship descriptions offer valuable insights into the organizations, their program objectives, and the attributes they seek in successful fellows. These descriptions, despite their brevity, serve as marketing tools that convey information about the organization's identity, values, and the transformative potential of the fellowship experience. In the subsequent sections, I analyze how fellowship descriptions reflect racialized and gendered expectations and how these expectations influence the diversity of candidates. The analysis focuses on two key aspects: the presence of racialized language and the use of gendered descriptors. The analysis of fellowship advertisements reveals significant patterns of racialized language that can impact the inclusivity and diversity of healthcare administrative fellowship programs. Specifically, a notable finding is that approximately 90% of the fellowship descriptions coded contained at least one example of racialized expectations, even though these biases were often subtle.

One common example of racialized language is the requirement that "candidates should exhibit a professional demeanor and communication style that aligns with our organization's values." This expectation reflects broader cultural biases, as notions of professionalism frequently adhere to White, Western norms. Professionalism is often defined by behaviors and communication styles that align with formal, hierarchical, and particular mannerisms traditionally associated with predominantly White cultures. Such norms may inadvertently marginalize candidates from diverse racial backgrounds who may express professionalism differently. By emphasizing these specific norms, organizations may exclude individuals whose professional demeanor does not conform to these traditional expectations.

Another prevalent example is the preference for "graduates from historically renowned programs." This phrasing can reinforce racial biases by favoring educational institutions that have historically been more accessible to predominantly White and affluent students. Prestigious institutions

often have a legacy of exclusivity, and prioritizing graduates from these programs can disadvantage candidates from institutions that have been historically underfunded or marginalized. This preference perpetuates existing disparities by valuing credentials from institutions that are less accessible to racially diverse students.

Additionally, phrases that emphasize cultural fit further highlight racialized expectations. For instance, an ad stating "we are looking for a candidate whose personality matches our dynamic and energetic team environment" suggests that there is a specific type of personality that aligns with the organization's culture. This language can reflect underlying assumptions about what constitutes a 'fit' for the team, often based on norms and values associated with a predominantly White or homogeneous group. Such descriptors can alienate candidates from diverse backgrounds who may have different expressions of dynamism and energy, potentially discouraging them from applying. Even though these biases may be subtle, their cumulative effect can significantly influence the diversity of the applicant pool.

The analysis of fellowship advertisements also reveaed a significant prevalence of gendered expectations, which may impact the gender diversity of candidates applying for healthcare administrative fellowship programs. The language used in these job ads frequently aligns with traditional masculine traits and stereotypes associated with leadership roles. For instance, phrases such as "He must have a strong executive presence and ability to lead large teams" explicitly associate effective leadership with masculine characteristics, reinforcing the stereotype that men are naturally more suited for management positions. Such language can discourage women and non-binary individuals from applying, as it implicitly suggests that they may not meet these traditional standards.

Additionally, many job ads emphasize traits such as being "powerful and assertive," which are often linked with masculinity. This emphasis on assertiveness and dominance can marginalize candidates who lead through collaboration and empathy, qualities traditionally associated with femininity.

Descriptions that require candidates to demonstrate a "commanding presence and authoritative communication style" further reinforce this gendered expectation, suggesting that effective leadership involves traits of control and dominance, typically seen as masculine. Similarly, ads that highlight the need for candidates to excel in "competitive, high-pressure situations" or to "take charge and drive results" reflect a preference for traits associated with traditional masculine stereotypes, such as aggression and competitiveness. This language may undervalue qualities like emotional intelligence and teamwork, which are often linked with femininity. Emphasizing a strong track record of leadership in "demanding environments" can also favor those with access to high-stakes roles, which are often more available to men due to systemic biases.

Despite these prevalent gendered descriptors, there are instances where job advertisements use more inclusive language. For example, some ads describe the ideal candidate as someone who "demonstrates strong leadership skills and the ability to collaborate effectively with diverse teams." Such language focuses on a range of leadership qualities and collaborative abilities, avoiding specific gendered traits and making the opportunity more accessible to a broader spectrum of candidates. The analysis underscores how gendered language in fellowship descriptions can reinforce traditional stereotypes about leadership and create barriers for women and non-binary individuals. However, the presence of gender-neutral language in some ads indicates that it is possible to describe leadership qualities in a more inclusive manner. Addressing these issues requires ongoing efforts to use language that reflects a diverse range of leadership styles and experiences, thereby promoting a more equitable and inclusive fellowship program.

2.6 Discussion

The healthcare sector’s increasing focus on health equity, diversity, and inclusion (DEI) reflects a broader societal imperative to address these critical issues within organizational frameworks. Integrating DEI into the education of early careerists is crucial, as administrative

fellowships offer pivotal opportunities for accelerated learning before assuming management roles. However, the extent to which these fellowships contribute to cultivating diverse healthcare leadership and advancing skills in DEI and health equity remains underexplored. The findings from this study reveal that despite initial efforts in 2020, there has been limited progress in fully integrating these elements into fellowship programs. Out of 889 fellowship listings analyzed, only 124 (14%) were dedicated to DEI or health equity, with 38 (31%) focusing exclusively on these areas. The remaining 86 (69%) offered rotations that included DEI-related initiatives but did not embed these principles as core components of the training. This discrepancy highlights the need for a more systematic integration of health equity, diversity, and inclusion across all fellowship types.

These findings are consistent with previous literature indicating that many organizations have not prioritized "increasing diversity in the leadership pipeline" as a central component of their fellowship recruitment strategy (Robbins et al., 2021). The limited focus on DEI and health equity within fellowship programs could have significant implications for patient care and outcomes. Persistent health disparities in the United States emphasize the necessity for leaders who are adept at promoting equitable care and developing strategies rooted in health equity. Without a strong emphasis on these aspects, fellowship programs may fall short in preparing leaders capable of driving meaningful change and addressing the needs of historically underserved populations. This lack of preparation could result in a leadership gap where future healthcare administrations are ill-equipped to tackle healthcare inequities and organizational challenges related to DEI and health equity.

Additionally, the study found that more than half of the fellowship programs offer customizable training experiences, which allows fellows to tailor their training based on their interests. While this flexibility has potential advantages, it also poses risks if DEI and health equity are not prioritized by preceptors and fellows. This could lead to these crucial areas being overlooked. The observation that health equity and DEI-focused fellowships or those with dedicated rotations are less common further supports the need for mandating these elements as central components of fellowship strategies. Ensuring that DEI and health equity are integral to fellowship programs is essential as healthcare organizations face increasing pressure to diversify leadership at all levels (Dreaschlin, Weech-Maldonado, Gail, Espane, & Wainio, 2017). Moving forward, making DEI and health equity mandatory components of fellowship programs could better prepare future leaders to meet these challenges.

The analysis also uncovered significant racialized and gendered expectations within fellowship advertisements. Racialized language was prevalent, with 90% of fellowship programs exhibiting at least one subtle form of racialized expectation. For example, phrases such as "candidates should exhibit a professional demeanor and communication style that aligns with our organization's values" often reflect white, Western norms of professionalism, which can marginalize candidates from diverse racial and cultural backgrounds. Similarly, language like "graduates from historically renowned programs are preferred" and "we are looking for a candidate whose personality matches our dynamic and energetic team environment" suggests a preference for candidates who conform to established cultural and institutional norms, potentially excluding diverse applicants.

Gendered expectations were also evident, with descriptions reinforcing traditional masculine traits associated with leadership. Phrases such as “he must have a strong executive presence and ability to lead large teams” and “seeking an individual who is powerful and assertive” emphasize qualities typically linked with masculinity. Such language can deter women and non-binary candidates from applying, implying that effective leadership is inherently masculine. Although some advertisements used more inclusive language, such as emphasizing “strong leadership skills and the ability to collaborate with diverse teams,” the overall trend reflects a significant gender bias.

Theoretical Implications

Institutional theory posits that understanding organizational structures and actions is inherently linked to their broader social environment (Martinez & Dacin, 1999). Institutions, defined as "regulative, normative, and cognitive structures and activities that provide stability and meaning for social behavior" (Scott, 1995), play a crucial role in shaping organizational practices and norms. According to institutional theory, organizations are influenced by external pressures and often adapt to these pressures to maintain legitimacy and stability. This perspective helps explain why organizations, including healthcare institutions, might adjust their practices in response to significant social movements, such as the tragic death of George Floyd. These movements can exert coercive, normative, and mimetic pressures on organizations, prompting changes in policies and practices aimed at enhancing diversity, equity, and inclusion (Scott, 1995).

However, this study reveals that despite the observed influence of social movements on organizational practices, there is a notable lag in the integration of DEI and health equity into

healthcare administrative fellowship programs. Although institutions may adopt DEI practices to align with normative pressures or mimic competitors, the actual incorporation of these principles into fellowship training remains superficial. The findings indicate that many fellowship programs still reflect underlying biases, including racialized and gendered expectations. For instance, language in fellowship advertisements often reinforces traditional norms of professionalism and leadership that align with white, Western standards, thus perpetuating existing biases.

The theory of racialized organizations extends this analysis by emphasizing that U.S. organizations are structurally designed to prioritize whiteness (Ray, 2019). This theory suggests that organizational structures and practices are inherently biased towards maintaining racial hierarchies and excluding diverse perspectives. Our findings illustrate this by showing how fellowship programs, even those adopting DEI language superficially, often fail to fully integrate diversity and health equity into their core objectives. This perpetuates a cycle where fellowship programs continue to educate future leaders who may not be adequately prepared to address the complexities of diverse patient populations and health disparities.

The integration of the theory of racialized organizations into our analysis highlights that while institutional theory explains why organizations may adopt DEI practices in response to external pressures, it does not fully account for the persistence of racial biases within these practices. This paper's findings suggest that organizations designed to uphold whiteness continue to produce fellowship programs that lack substantial DEI and health equity content. This misalignment between stated objectives and actual practices points to a broader issue of how organizational structures are designed to uphold systemic biases.

Addressing these gaps requires a critical reexamination of how fellowship programs are designed and implemented. Efforts to enhance the impact of administrative fellowships should include a fundamental shift in curricula to embed DEI and health equity as integral components of training. This involves not only adapting educational content but also fostering new relationships and expanding practice-based experiences that address the needs of diverse populations. By integrating a more nuanced understanding of racialized organizations, we can better align fellowship programs with the essential goal of preparing leaders capable of advancing health equity and navigating the complexities of a diverse healthcare landscape.

Future Research and Limitations

The findings should be interpreted in light of the study's limitations. While the ACHE fellowship directory serves the purpose of providing a list of available postgraduate administrative fellowships to students and early careerists while allowing sponsoring organizations to promote and increase visibility for their programs. It is important to note that the ACHE fellowship directory does not encompass a comprehensive list of all available fellowships nationwide. As noted in the methodology section, we could not get a comprehensive view of the fellowship listings offered in 2017 and 2018, because they only had archival data for those years. Secondly, given that over half of the fellowships were coded as customizable, from the fellowship database alone, we cannot directly say anything about the varied experiences of fellows during the fellowship training period. It is likely that some fellows, given their interests, might express interest in health equity and DEI principles, but that information cannot be ascertained from the current database. We also acknowledge that our finding that preceptors differ based on fellowship type may be attributed to the recent creation of Chief DEI and Chief Health Equity positions within the last three years, thus potentially affecting our analysis.

Managerial and Health System Implications

Despite these limitations, the current study is important for documenting the current healthcare administration fellowship landscape in the United States, and the power they have to influence the current trajectory of healthcare administrative leaders who are not only prepared to manage with strategy and finance skill sets, but with the mindset that health equity and diversity, equity, and inclusion need to be embedded within all aspects of the organization. It is essential for fellowship programs to adopt a framework that firmly establishes DEI and health equity as integral components of the training experience. This framework could involve incorporating dedicated rotations or projects on these topics, ensuring that senior leaders with DEI and health-equity focused roles are actively engaged as preceptors and mentors in the fellows' growth and development, and implementing accountability mechanisms to assess progress in these areas.

By taking such actions, administrative fellowship programs can evolve to prioritize and explicitly include specific language dedicated to DEI, as well as health equity, regardless of the fellowship's specialized focus. Making health equity and DEI a fundamental organizational priority will consequently make it an intrinsic priority for fellowship programs, even if individual applicants pursue specialized training opportunities in finance or supply chain management. Health equity and DEI must no longer be considered optional but rather embedded into the very essence of fellowship programs, starting from the initial description and marketing stages. This ensures that the fellows receive comprehensive training, equipped with the necessary tools to address healthcare disparities, cultivate a safe and diverse workforce environment and culture, and promote equitable care throughout their careers.

References

A Theory of Racialized Organizations—Victor Ray, 2019. (n.d.). Retrieved May 11, 2023, from https://journals.sagepub.com/doi/10.1177/0003122418822335

All Lives Matter, but so Does Race: Black Lives Matter and the Evolving Role of Social Media—Nikita Carney, 2016. (n.d.). Retrieved September 29, 2023, from https://journals.sagepub.com/doi/abs/10.1177/0160597616643868

Baquet, C. R. (2014). Hero: David Satcher, MD, PhD. *Journal of Health Care for the Poor and Underserved, 25*(1), 1–3.

Black Lives Matter: A Commentary on Racism and Public Health | AJPH | Vol. 105 Issue 8. (n.d.). Retrieved September 29, 2023,

from https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2015.302706

Casile, M., & Davis-Blake, A. (2002). When Accreditation Standards Change: Factors Affecting Differential Responsiveness of Public and Private Organizations. *The Academy of Management Journal*, *45*(1), 180–195. https://doi.org/10.2307/3069291

Chandra, A., Frakes, M., & Malani, A. (2017). Challenges to Reducing Discrimination and Health Inequity Through Existing Civil Rights Laws. *Health Affairs (Project Hope)*, *36*(6), 1041–1047. https://doi.org/10.1377/hlthaff.2016.1091

Cronin, G. M. (2014). Perspectives of Fellowship Programs: The Cleveland Clinic Experience in Developing Administrative Fellows. *Journal of Health Administration Education*, *31*(4), 313–320.

Dowling, J., & Pfeffer, J. (1975). Organizational Legitimacy: Social Values and Organizational Behavior. *The Pacific Sociological Review*, *18*(1), 122–136. https://doi.org/10.2307/1388226

Enard, K. R., Dotson, E., Broom, K., Dean, C., Wiltshire, J., & Elder, K. (2017a). *Diversity and Inclusion in Graduate Healthcare Management Education: Perspectives from program directors and students*.

Enard, K. R., Dotson, E., Broom, K., Dean, C., Wiltshire, J., & Elder, K. (2017b). Diversity and inclusion in graduate healthcare management education: Perspectives from program directors and students. *Journal of Health Administration Education*, *34*(2), 191–212.

Ford CL, Airhihenbuwa CO. The public health critical race methodology: praxis for antiracism research. Soc Sci Med. 2010 Oct;71(8):1390-8. doi: 10.1016/j.socscimed.2010.07.030. Epub 2010 Aug 11. PMID: 20822840.

Garman, A. N., Wainio, J. A., & Rowland, M. (2014). Graduate and Fellowship Program Leaders Perspectives on Administrative Fellowships: Results from Two National Surveys. *Journal of Health Administration Education*, *31*(4), 349–359.

Gaskin, D. J., Thorpe, R. J., McGinty, E. E., Bower, K., Rohde, C., Young, J. H., LaVeist, T. A., & Dubay, L. (2014). Disparities in diabetes: The nexus of race, poverty, and place. *American Journal of Public Health*, *104*(11), 2147–2155. https://doi.org/10.2105/AJPH.2013.301420

Gonzales, G., Quinones, N., & Martin, M. (2018). Health Equity Curricula Within Health Policy and Management Concentrations in U.S. Public Health Graduate Programs. *Pedagogy in Health Promotion*, *5*, 237337991881402. https://doi.org/10.1177/2373379918814024

Gooding-Williams, R. (Ed.). (2013). *Reading Rodney King/Reading Urban Uprising*. Routledge. https://doi.org/10.4324/9780203699997

Green, A. R., Carney, D. R., Pallin, D. J., Ngo, L. H., Raymond, K. L., Iezzoni, L. I., & Banaji, M. R. (2007). Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *Journal of General Internal Medicine*, *22*(9), 1231–1238. https://doi.org/10.1007/s11606-007-0258-5

Haddock, C. C., McLean, R. A., & Chapman (FACHE.), R. C. (2002). *Careers in Healthcare Management: How to Find Your Path and Follow it*. Health Administration Press.

Haider, A. H., Schneider, E. B., Sriram, N., Dossick, D. S., Scott, V. K., Swoboda, S. M., Losonczy, L., Haut, E. R., Efron, D. T., Pronovost, P. J., Lipsett, P. A., Cornwell, E. E., MacKenzie, E. J., Cooper, L. A., & Freischlag, J. A. (2015). Unconscious race and social class bias among acute care surgical clinicians and clinical treatment decisions. *JAMA Surgery*, *150*(5), 457–464. https://doi.org/10.1001/jamasurg.2014.4038

Hersch, J., & Shinall, J. B. (2015). FIFTY YEARS LATER: THE LEGACY OF THE CIVIL RIGHTS ACT OF 1964: The Legacy of the Civil Rights Act of 1964. *Journal of Policy Analysis and Management*, *34*(2), 424–456. https://doi.org/10.1002/pam.21824

Iglehart, J. K. (2014). Diversity dynamics—Challenges to a representative U.S. medical workforce. *The New England Journal of Medicine*, *371*(16), 1471–1474. https://doi.org/10.1056/NEJMp1408647

Implicit bias in healthcare professionals: A systematic review | BMC Medical Ethics | Full Text. (n.d.). Retrieved September 29, 2023,

from https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8

Increasing and Sustaining Racial Diversity in Healthcare Leadership. (n.d.). Retrieved May 11, 2023, from https://www.ache.org/about-ache/our-story/our-commitments/policy-statements/increasing-and-sustaining-racial-diversity-in-healthcare-management

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. (2003). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (B. D. Smedley, A. Y. Stith, & A. R. Nelson, Eds.). National Academies Press (US). http://www.ncbi.nlm.nih.gov/books/NBK220358/

Kim, J., & Angnakoon, P. (2016). Research using job advertisements: A methodological assessment. *Library & Information Science Research*, *38*. https://doi.org/10.1016/j.lisr.2016.11.006

Lomperis, A., Howard, D., & Turner, J. (2014). The Future of Healthcare Management Fellowships: Opportunities, Needs, and Recommendations. *The Journal of Health Administration Education*, *31*, 385.

Lyness, K. S., & Grotto, A. R. (2018). Women and Leadership in the United States: Are We Closing the Gender Gap? *Annual Review of Organizational Psychology and Organizational Behavior*, *5*(1), 227–265. https://doi.org/10.1146/annurev-orgpsych-032117-104739

Martinez, R. J., & Tina Dacin, M. (1999). Efficiency motives and normative forces: Combining transactions costs and institutional logic. *Journal of Management*, *25*(1), 75–96. https://doi.org/10.1016/S0149-2063(99)80004-X

Mitchell, D. A., & Lassiter, S. L. (2006). Addressing Health Care Disparities and Increasing Workforce Diversity: The Next Step for the Dental, Medical, and Public Health Professions. *American Journal of Public Health*, *96*(12), 2093–2097. https://doi.org/10.2105/AJPH.2005.082818

Ong, P., Cheng, A., Pech, C., Gonzalez, S. (2017). Retrieved September 29, 2023, from https://ucla.app.box.com/s/hx75jfhx1cudm89i72oisonwrq8nhihh

Paciello, A. (2014). *Perspectives of Fellowship Programs: The Massachusetts General Hospital Fellowship Experience*.

Persily, E. by N., Citrin, J., & Egan, and P. J. (Eds.). (2008). *Public Opinion and Constitutional Controversy*. Oxford University Press.

Perspectives of Fellowship Programs: The Massachusetts General Hospital Fellowship Experience. (n.d.). Retrieved September 29, 2023, from https://www.researchgate.net/publication/275368086_Perspectives_of_Fellowship_Programs_The_Massachusetts_General_Hospital_Fellowship_Experience

Robbins, C. J., Bradley, E. H., & Spicer, M. (2001). Developing leadership in healthcare administration: A competency assessment tool. *Journal of Healthcare Management / American College of Healthcare Executives*, *46*(3), 188–202.

Robbins, J., Garman, A. N., Boren, S., Haga, R., Hall, R. S., Killaly, C., Simms, J., & Song, P. (2021). *What is the value of administrative fellowships in the era of COVID-19?*

Robbins, J., Graham, B. Z., Garman, A. N., Smith Hall, R., & Simms, J. (2022). Closing the Gender Gap in Healthcare Leadership: Can Administrative Fellowships Play a Role? *Journal of Healthcare Management / American College of Healthcare Executives*, *67*(6), 436–445. https://doi.org/10.1097/JHM-D-21-00314

Rosa, J. D. (2016). Standardization, Racialization, Languagelessness: Raciolinguistic Ideologies across Communicative Contexts. *Journal of Linguistic Anthropology*, *26*(2), 162–183. https://doi.org/10.1111/jola.12116

Sage Research Methods—The Content Analysis Guidebook. (n.d.). Retrieved September 29, 2023, from https://methods.sagepub.com/book/the-content-analysis-guidebook-2e

Suchman, M. C. (1995). Managing Legitimacy: Strategic and Institutional Approaches. *The Academy of Management Review*, *20*(3), 571–610. https://doi.org/10.2307/258788

The Institute of Medicine Report: Health Professions Education: A Bridge to Quality—Kathleen Ann Long, 2003. (n.d.). Retrieved September 29, 2023, from https://journals.sagepub.com/doi/abs/10.1177/1527154403258304

The iron cage revisited institutional isomorphism and collective rationality in organizational fields | Emerald Insight. (n.d.). Retrieved September 29, 2023, from https://www.emerald.com/insight/content/doi/10.1016/S0742-3322(00)17011-1/full/html

Thomas, K. M. (Ed.). (2008). *Diversity resistance in organizations* (pp. xxx, 332). Taylor & Francis Group/Lawrence Erlbaum Associates.

Thompson, J. M., & Temple, A. (2015). Early Careerist Interest and Participation in Health Care Leadership Development Programs. *The Health Care Manager*, *34*(4), 350–358. https://doi.org/10.1097/HCM.0000000000000082

Understanding Diversity Management Practices: Implications of Institutional Theory and Resource-Based Theory. (n.d.). https://doi.org/10.1177/1059601110390997

W. Richard SCOTT (1995), Institutions and Organizations. Ideas, Interests and Identities.Paperback: 360 pages Publisher: Sage (1995) Language: English ISBN: 978-142242224. (2014). *M@n@gement*, *17*(2), 136–140. https://doi.org/10.3917/mana.172.0136

What is the value of administrative fellowships in the era of COV...: Ingenta Connect. (n.d.). Retrieved September 29, 2023, from https://www.ingentaconnect.com/contentone/aupha/jhae/2021/00000038/00000001/art00009

Williams, J. S., Walker, R. J., & Egede, L. E. (2016). Achieving Equity in an Evolving Healthcare System: Opportunities and Challenges. *The American Journal of the Medical Sciences*, *351*(1), 33–43. https://doi.org/10.1016/j.amjms.2015.10.012

Chapter 3 Sandwiched in the Middle: Hospital Administrators and Perceptions of Organizational Efforts to Advance Health Equity

Middle managers have had so much piled onto them. Their development, their well-being, has often been an afterthought. We have to make up for it, because when we think about creating resilient organizations, resiliency starts with having a really strong middle management team that's able to really drive.

—Emily Field, Co-Author of Power to the Middle: Why Managers Hold the Keys to Future Work

3.1 Background

Sociologists have maintained a longstanding interest with the roles of middle managers within organizations (Mills, 1951; Burns, 1957; Bendix, 1963; Weber, 1978). When the sociologist C. Wright Mills conducted his seminal work in the 1950s on the emergence of white-collar workers, he described middle managers in rather disparaging terms, likening them to mere cogs in the bureaucratic machinery: "You are the cog and the beltline of the bureaucratic machinery itself… and such power as you wield is a borrowed thing. Yours is the subordinate's mark, yours is the canned talk… you are the servant of decision, the assistant of authority." While this characterization is now viewed by some as unjust and inaccurate (Osterman, 2010), it does underscore the fundamental distinction between middle management and senior leadership. Senior management designs a strategy that sets the organization's course, whereas middle management interprets and executes those decisions (Mintzberg, 1989: 98; Osterman, 2010; Gjerde, 2020).

The enduring dominance of bureaucratic systems, characterized by formal hierarchy and procedures, continue to dominate US organizations (Zhang, 2023). It is unsurprising, then, that the perception of middle managers as unremarkable, average overseers has persisted over decades. In a

seminal 1977 Harvard Business Review (HBR) article, Zaleznik drew a clear, explicit distinction between being a leader (an inspirational visionary) and a manager (a strategic administrator). These conceptual distinctions remain ingrained in many Master of Business Administration (MBA) and executive development programs, which often aim to guide managers towards "upgrading" and transitioning into leadership roles (Jaser, 2021; Watkins, 2012). Today, 13 percent of the workforce is classified by the U.S. census as managers, with 19% of reporting that they supervise others as a major part of their job (Zhang, 2023).

Management scholar John Kotter systematically examined the activities of middle managers and identified "agenda setting" as their primary function (Kotter, 2019). However, the context within which these decisions are made is often beyond the manager's control. Middle managers frequently find themselves constrained by the trajectory of their careers and the nature of their work environment, with limited influence over organizational strategy (Zhang, 2023; Osterman, 2010). In this regard, they differ from both senior executives and frontline workers. This means that when organizations opt to streamline their organizational hierarchies and look for ways to automate processes, middle managers often bear the brunt of layoffs and restructuring (Rovella, 2024). In 2023, 31.5% of layoffs affected middle managers - nearly a 12% percentage-point increase from 2018 (Kayser, 2024).

Those who remain are often underinvested in or even ignored, leading to stagnation in skill development amidst rapidly evolving organizational landscapes. Many middle managers have reported feelings of being underappreciated, typically pointing to the lack of information or poor information from senior executives (Belasen, 2014). Studies show that middle managers operate within the realm of difficult policies, procedures and guidelines, (Field, Hancock, Mugayar-Baldocchi, & Schaniger, 2023), and without a consistent flow of communication from the top, are often left unsure of what is required of them (Kras & Taxman, 2017; Lynch & Rogers, 1986). On the other hand, some middle managers note that they are free to be "intrapreneurs," to take ownership over their career and enjoy the benefits of mobility and transferable skills (Osterman, 2010).

The Role of Middle Managers in Healthcare & What Their Position Means for Health Equity

While middle managers face similar challenges and advantages across diverse organizational contexts, healthcare has been a notable area with extensive research focusing on understanding their role and contributions to organizational strategy, innovation, and execution (Emberston, 2006; Frederico & Bonacum, 2010; Birken, Lee, & Weiner, 2012; Buchanan, Denyer, Jaina, et al., 2013; Belasen, 2014). This line of inquiry emerged following an evolution in modern healthcare organizations, which embraced being "larger, smaller, and flatter" (McConnell, 2005). The 1990s witnessed a surge in merger and acquisition activities within the healthcare industry, leading to a phenomenon known as "organizational flattening" (McConnell, 2005). Organizational flattening involves streamlining the overall structure by eliminating layers of the hierarchy. Intense competition on the price of care and a shifting environment compelled many delivery systems to downsize staff and curtail services to ensure viability (Baker, 2001). Business buzzwords like reorganization, reengineering, and continuous improvement called for the streamlining of processes to gain competitive advantage (Emberston, 2006).

During the COVID-19 pandemic, the pattern of widespread layoffs affecting middle management roles emerged as a strategy to cut costs and streamline operations amidst crisis (Field, Hancock, Schaninger, 2023; Samreen, Nagi, Naseem, & Gul, 2022). This action raised questions about the perceived value of middle managers in healthcare settings. Studies offer varied perspectives about the contributions of middle managers. Some research acknowledges the benefits of middle managers', arguing that they have great potential to influence healthcare innovation (Birken, Lee, & Weiner, 2012), facilitate or enhance implementation processes or improve organizational performance (Caldwell, Chatman, O'Reilly, Ormiston, & Lapiz, 2008; Wooldrige & Floyd, 1990), and bridge informational gaps that exist between senior management and frontline clinicians (Birken et al., 2012, 2016; Engle et al., 2017). Other research suggests that while there are benefits to middle managers, many organizations are not leveraging the role appropriately (Field, Hancock, Mugayar-Baldocchi, & Schaninger, 2023) . Middle management is often treated as a catchall, requiring them to spend much of their time handling nonmanagerial work and navigating organizational bureaucracy rather than allowing them to focus on the most important roles within the organization. These roles include leading their team to higher

organizational performance, driving effective organizational operations, and providing the link between organizational vision and execution (Field, Hancock, Mugayar-Baldocchi, & Schaninger, 2023).

Across the board, however, the current literature has predominantly focused on senior leaders, with a notable lack of attention on the influence of middle managers in organizational change efforts (Birken et al., 2012, Feifer & Ornstein, 2004, Hagedorn et al., 2006, Noble, 1999). For example, studies have underscored the importance of senior leadership in fostering innovation and enhancing performance within healthcare facilities, emphasizing the essential role of leadership support in organizing the resources required for successful innovation implementation (Chaung, Jason, & Morgan, 2011, Plsek & Wilson, 2001). However, the current literature still falls short in adequately examining senior leaders whose roles are dedicated to health equity or diversity, equity, and inclusion (DEI) strategic efforts, and how these roles play a critical role in reducing health disparities and improving healthcare workforce diversity efforts in the United States (see Chapter 3). Furthermore, scant attention has been paid to middle managers tasked with advancing health equity or executing equity-focused goals. Virtually no analysis exists on how middle managers perceive organizational progress towards health equity goals. This oversight leaves critical questions unanswered: How do middle managers charged with health equity goals perceive their roles? Who do they identify as the primary drivers of health equity change within their organization, and do they believe their organization is on the right path? How do their experiences relate to their perceptions of organizational efforts to advance health equity?

Given the stagnation in eliminating racial and ethnic health disparities over the past two decades (Mahajan, Carabello, Lu et al., 2018), understanding middle managers' roles in health equity and their perceptions of organizational commitment is crucial. Research indicates that only 8% of adults in the United States receive all recommended preventive services, with some receiving unnecessary or harmful care (Borsky, Zhan, Miller, Ngo-Metzger, Bierman, & Meyers, 2018). Disparities persist among racial and ethnic minorities, low-income individuals, and women, who face higher rates of diseases like cancer, obesity, and cardiovascular issues (Baciu, Negussie, Geller et al., 2017). Notably, men often receive better treatment for heart disease than women (Okunrintemi et al., 2018), and Black men have one of the

shortest life spans among all Americans (Bond & Herman, 2016), while Black women are three times more likely to die from pregnancy-related causes than white women (Njoku, Evans, Nimo-Sefah, & Bailey, 2023). Significant variations in healthcare quality measures exist across practice sites and units (Campbell et al., 2010). Many of these disparities stem from healthcare organizations' failure to deliver culturally appropriate care and structural racism's pervasive impact in healthcare, shaping the US healthcare system to advantage the White population — the racial group in power (Yearby, 2000).

The recent proliferation of Offices of Health Equity and Offices of Diversity, Equity, and Inclusion (DEI) nationwide marks a significant shift in the landscape (Dolan, 2013; Raths, 2020; Uehling, Hall-Clifford, Kinnard, & Wimberly, 2023; Kayser, 2023). The transition of some health equity roles reporting directly to Chief Health Equity Officers emphasizes middle managers' unique position. They contribute to strategic discussions and provide crucial input as executors, offering perspectives on whether their organization is truly advancing organizational enactments of equity through policies or programs that are more performative than productive of real organizational transformation (Melaku & Winkler, 2022). Unfortunately, their leaders, such as Chief Health Equity Officers or Chief DEI Officers, are frequently ill-positioned for success in their roles (see Chapter 3), which can have cascading negative effects on their teams and impede effective change. To comprehend how health equity is actualized, research must delve into the "middle" of organizations to understand how things truly get done. Middle managers with critical roles in improving the health and well-being of their members or patient populations bring executive leaders or broader organizational strategic goals to life. They also influence decisions made by senior and executive-level management, particularly in the healthcare sector. Thus, middle managers are responsible not only for executing the strategy but also for negotiating and expanding it when it falls short of its intended purpose.

3.2 Theoretical Framing

Middle managers in healthcare, regardless of their racial or ethnic background, work within and are affected by the pervasive impact of organizations acting as race-neutral bureaucratic structures. These

structures, while seemingly impartial, are inherently racialized, with race shaping the very foundations, hierarchies, and operational processes of these institutions (Ray, 2019; Wingfield and Alston, 2014; Wooten and Couloute, 2017). As intermediaries between senior leadership and frontline staff, middle managers often contend with how race influences power dynamics, resource distribution, and patient care within healthcare systems, whether they are consciously aware of it or not. This holds especially true for middle managers whose responsibilities are centered on advancing health equity, as they are often charged with spearheading initiatives that address racial and ethnic disparities in access to care. While in their roles, they may leverage their positional authority, mobilize collective action, or advocate for policies and practices that dismantle racialized barriers to health equity. They may also confront ethical dilemmas when organizational priorities perpetuate racial inequalities or conflict with organizational commitment to social justice and equity.

These actions place them in a unique position to challenge and reshape institutional norms that perpetuate racial inequities. However, their ability to effect meaningful change is often constrained by entrenched systems of privilege and oppression that govern organizational behavior. Victor Ray's theory of racialized organizations, which is discussed in previous chapters of this dissertation (see Chapters 1 through 3), provides a framework to explore how middle managers' perceptions of organizational efforts to advance health equity are shaped by the racialized dynamics inherent within their organizations, regardless of whether the manager is cognizant of this influence. Sociologists have begun to consider how the organizations can have an identity that allows them to be racialized much in the same way that people are (Wooten and Couloute, 2017). As racialized spaces, organizational beliefs, rituals, norms, and even language can reproduce racial inequality (Wingfield, 2020).

For example, middle managers might find themselves navigating discriminatory practices in promotion and hiring processes, where implicit biases favoring certain racial groups hinder the advancement opportunities of others (Greenwald, 2022). Additionally, the allocation of resources within the organization may be skewed, with initiatives or offices predominantly serving communities of color receiving less funding and support compared to initiatives that serve predominantly white communities

(Himmelstein, Caesar, & Himmelstein, 2022). These examples illustrate how racialized dynamics within organizations might affect the experiences of middle managers. As a result of examples like these, middle managers may have varied perceptions of organizational success and what health equity advancement looks like within their organization.

Perceptions of Organizational Success and Racialized Organizations

For decades, management scholars have explored how employees interpret their work environments (Weick, 1977; Brown, 1978; Salancik and Pfeffer, 1978). Research reveals that employees selectively focus their attention on certain organizational features, leading to the retention of more information about these aspects (Cameron & Whetten, 1981). When assessing their surroundings, individuals tend to hone in on organizational elements where they possess the most information, rather than considering the organization in a broader context (Taylor and Fiske, 1978). Amidst rapid organizational change, scholars recognize the potential negative impact organizational change may have on employee perception and productivity (Weber & Weber, 2000). Employees may exhibit skepticism towards change initiatives, actively or passively resisting them, resulting in unsuccessful change efforts, decrease in morale and productivity, and increases in turnover or subsequent organizational failures (Raza et al., 2023; Khaw et al., 2023; Dervitsiotis, 1998; Ebay et al., 2001; Goldlerstein, 1988). While existing literature acknowledges that employee perception of organizational success is influenced by factors like leadership effectiveness and organizational change, there is limited analysis on how racialized organizational contexts might uniquely shape employee's interpretations of success.

Scholars, like Adia Wingfield (2020), have explored how organizational position and occupational role reveal different views of the organization. Her work, which studied differences in perception among clinicians along the organizational hierarchy (doctors vs. nurses vs. technicians) reveals that jobs at different levels within the organization require varying responsibilities and qualifications, and internal processes such as wage-setting and job classification help maintain racial segregation across the organizational hierarchy (Wingfield, 2020). She also finds that Black workers at

the top of the organizational hierarchy have a perspective on discrimination that spans multiple organizations and fields, thus making them attuned to the ways discrimination can be institutionalized within and across social structures. However, Black workers who are lower in the organizational hierarchy face organizational discrimination as well, but they are more likely to see this as a function of individual preferences and choices and less likely to attach their experiences to more structural sources of discrimination (Wingfield, 2020). However, similar work has not been replicated in the context of administrative professionals, such as executive management versus middle management versus frontline supervisors.

3.3 Objective

In Chapter 3, I interview Black executive leaders with health equity or diversity, equity, and inclusion (DEI) focused roles to understand how race intersects with organizational and institutional processes, detrimentally affecting their career aspirations and leadership capabilities. This paper adds to the literature by examining how **occupational role and position** reveal varying outlooks on organizational success as it relates to health equity efforts at their hospital or health system. While this paper does not focus on the race of the interviewees, it offers a meaningful review of middle managers, who often report to or closely engage with health equity leaders, and how they interpret success as those who execute decisions. This is contrasted with the perspective of executive leaders in Chapter 3, who set organizational vision but likely take a broader view and do not execute the work themselves.

Previous research indicates that organizational position and occupational role shape distinct views of the organization (Wingfield, 2020). However, there is limited understanding of how hierarchical position influences perceptions of a health system's commitment to health equity. This study examines how middle managers perceive their organization's health equity efforts and how these perceptions impact their daily work and overall view of the organization. Drawing on in-depth interviews with middle managers responsible for planning, designing, and implementing health equity initiatives, this chapter will:

1. Describe middle managers' views on organizational commitment to health equity initiatives.
2. Analyze the strategies middle managers use to overcome barriers and promote health equity.
3. Identify the benefits and challenges middle managers face in implementing health equity strategies within their departments.
4. Make recommendations for fostering collaboration and alignment between middle management and executive leadership, addressing differences in perspectives and strategies for successful advancement of health equity goals.

3.4 Study Design and Methodology

For this study, I analyzed interviews with middle managers who provided insights into their roles in initiating and implementing equity-focused initiatives within their respective organizations. The interview data used in this study were gathered as part of the Racial Equity Approach to Nonprofit Hospitals' Community Benefit Program Planning, Design, and Implementation study, funded by a University of Michigan Equity Grant (PI: Simone Singh). The project sought to explore the factors and processes that drive nonprofit hospitals' willingness and ability to implement community benefit initiatives aimed specifically at addressing structural racism and promoting health equity.

Sampling Frame & Recruitment

The data collection method for this study involved purposive and convenience sampling of nonprofit hospitals across the United States. Hospitals and hospital administrators were recruited through multiple channels. First, two study team members, with prior experience working with hospital administrators and the Catholic Health Association, leveraged their contacts to recruit potential interviewees. Second, participants were recruited during the American Hospital Association (AHA) 2023 annual conference on health equity. Third, the study team sought assistance from the AHA nursing board director to invite nurse executive members involved in community benefit and health equity. To ensure diverse representation, the study aimed to contact hospitals from four regions of the US (West, Midwest, South, Northeast), teaching and non-teaching institutions, rural and urban settings, with varying bed counts, and from states with and without community benefit reporting requirements.

Semi-structured interviews were conducted via Zoom from October 2022 to July 2023, with participants' consent. The interviews were recorded for analysis. Two team members conducted interviews to facilitate post-interview debriefing and discussion of major themes. Interviews were de-identified to maintain anonymity. Semi-structured interviews were conducted via Zoom from October 2022 to July 2023, with participants' consent. The interviews were recorded for analysis. Two team members conducted the interviews to facilitate post-interview debriefing and discussion of major themes. Interviews were de-identified to maintain anonymity. Data saturation, indicating sufficient data collection, was gauged using the qualitative grounded theory method, reaching a total of 23 hospital administrators. Three interviews were eliminated because they did not meet the definition of middle managers: one interviewee was an administrative fellow, participating in a fellowship program to learn managerial skills, and the other two were vice presidents. This left a total of 20 interviews for analysis. Middle managers are defined here, similar to other literature, as staff with a supervisory capacity other than senior leaders (e.g., department managers, program managers, nurse managers, administrative directors, frontline supervisors) (Engle et al., 2017).

The interviews began with an open-ended question allowing participants to provide an overview of their hospital and their duties. Subsequent questions, focused on equity-focused community benefit initiatives' initiation and implementation. Probes specific to the three phases of equity-focused implementation were employed. While the interview guide directed the discussions, participants were encouraged to share their perspectives without direct inquiries about racial equity to ensure authenticity. Thematic saturation determined the completion of interviews.

Analysis

The analysis for this study employed a narrative approach consistent with the qualitative methodology outlined by Feldman, Skoldberg, Brown, and Horner (2004), which prioritizes the interpretation of participants' stories and experiences. This approach allowed for an in-depth

understanding of how middle managers perceive and navigate organizational efforts towards health equity.

To ensure a comprehensive understanding of the data, interviews were transcribed professionally and subsequently coded using MAXQDA software. In this chapter, participants are referred to using "P" followed by their participant ID number to maintain confidentiality and ensure a clear, systematic presentation of their insights. I was the sole coder for this study. The coding process began with the development of a preliminary coding scheme based on the interview questions. This initial framework guided the subsequent analysis. During the preliminary phase, I reviewed a small subset of transcripts in Microsoft Word, annotating potential codes, themes, and necessary adjustments to the coding structure. These annotations informed the refinement of the codebook.

The coding and re-evaluation phase involved the systematic application of codes to all transcripts using MAXQDA. As the sole coder, I analyzed the data, identifying areas within the codebook that required attention. This iterative process included revising codes, providing clarifications where needed, and incorporating any missing codes.

The following codes were applied during the analysis:

1. **Organizational-Level Commitment:** Participants' perceptions of their organization's overall commitment to health equity efforts.
2. **Executive-Level Commitment:** Participants' perceptions of their leaders' or upper management's commitment to health equity.
3. **Individual-level Commitment:** Participant's perceptions of their commitment to health equity and ability to successfully do their role as a middle manager
4. **Description of Health Equity Strategy:** Exploring the strategies employed by participants to promote health equity within their departments.
5. **Resources:** Assessing the resources available to participants, including financial support and staffing.

6. **Measurement of Health Equity Goals:** How participants measure and evaluate the success of health equity initiatives.

3.5 Results

This section demonstrates how middle managers perceive their organization's commitment to health equity. Through thematic analysis, six key areas emerged: executive leadership commitment, organizational-wide commitment, individual-level commitment to health equity, resource allocation, goal measurement, and health equity strategic development. Under each bolded topic area, themes are listed and described. Illustrative quotes and explanations of each theme are included.

Executive Leadership, Organizational, and Individual Commitments

Middle managers' perceptions of executive leadership commitment to health equity, organizational-wide commitment, and their own individual contributions were categorized into three primary sentiments: *positive, indifferent, and negative*. Positive perceptions highlighted instances where middle managers observed either strong support and visible dedication from executive leaders toward advancing health equity agendas or a culture of inclusivity and prioritization of health equity across the organization. Indifferent sentiments depicted a state of ambiguity or uncertainty among middle managers regarding the level of commitment demonstrated by executive leadership and the organization as a whole, as well as their own role in contributing to health equity. Negative perceptions, on the other hand, indicated skepticism, dissatisfaction, or perceived lack of emphasis or action from executive leaders and the organization in promoting health equity initiatives, as well as feelings of inadequacy or frustration stemming from perceived barriers hindering their ability to contribute effectively to health equity efforts.

Positive Perceptions of Organizational and Executive Leadership Commitment

Several middle managers reflected a positive outlook on the organization’s efforts to advance health equity. For example, there was an acute awareness of how organizations compare their performance against other organizations, not only to stay aligned with organizational trends but also to

avoid public scrutiny in an increasingly socially conscious landscape. One participant articulated this sentiment, stating:

> **P1**: "Why are we funding the same organizations over time?..How many organizations are led by someone with a marginalized identity? Those are the types of questions that my organization considers and are currently being infused into the work. That's really exciting now. I think the investments always had a significant meaning and value but it's just now taking a health equity lens, which is new."

They recognize that organizations consider how they are perceived by external stakeholders and how those perceptions may influence decision-making processes. During the interview, they viewed their organization's reflections to be a commitment to continuous improvement and a willingness to learn from best practices in the field to advance health equity. While this manager acknowledged the questions that their organization is considering to advance health equity within their organization, another participant details potential factors that are leading organizations to ask these questions. For example, the impact of external factors, such as the COVID-19 pandemic and heightened awareness of systemic racism, catalyzed organizational responsiveness to health equity imperatives. The participant stated:

> **P4:** "I think it was the impact of COVID and the long overdue acknowledgement of racism as a public health emergency that made hospitals have a genuine engagement, and serve as an anchor institution, to really be a leader in that space. And so there was a lot of public pressure to do something, understandably."

This participant shows an understanding of the interconnectedness between organizational imperatives and broader socio-political dynamics. They appeared pleased with the notion that external accountability mechanisms frequently influence organizational behavior. The impact of COVID-19 and discussions related to racism in the United States, in this case, led to deeper discussion about what organizations are doing to serve historically excluded patient populations. However, other participants took a different lens,

and discussed how their organization's mission, values, and culture really drive health equity efforts. They stated:

> **P3:** "There is a mission component. We follow Catholic social teaching .. which has always told us that we are there to serve and that we are especially there to serve those who are poor, vulnerable, and marginalized. I think we hone in on that.. But, I think those policy requirements really make it important. It puts a little more gusto behind it."

> **P12:** "You are gonna have people that get it and people that don't. And so I would say more than not, it is ingrained to our culture and people do get it, but oftentimes at least we have the right folks at the table that can push back and say, "Hey, we're not thinking through this, we haven't thought about X, Y, and Z, and how this is maybe gonna affect our low-income population."

While highlighting the importance of aligning organizational actions with mission-driven principles, participant three demonstrates an understanding of the complementary role that policy plays in decision-making processes. They recognize that such requirements not only add impetus to health equity priorities but help to reaffirm the organization's commitment to its mission. Participant twelve, however, recognizes that everyone within their organization does not understand health equity. However, they have had a positive experience because 1) health equity principles are ingrained into their culture and 2) they have employees with decision-making authority who ask health equity related questions in leadership discussions.

While most middle managers focused on organizational commitment to health equity, several spoke directly about executive DEI and Health Equity leaders and their role in advancing health equity within the organization. They stated:

> **P7:** "Equity was kind of a second thought and in healthcare, I feel like. You see all the studies of bias and things like that. We still work very hard to have equity show up the way it does in

community within our four walls of the institution. We have a Chief Diversity Officer who is amazing and is really changing the way that we do business in that sense."

P10: "We have a new Equity Officer. Our whole community health improvement service line is now under diversity, equity, and inclusion, which is really exciting. We have three strategic pillars. It is centered around community, people, and patients. This is a very exciting time to be a part of the work."

These quotes reflect positive perceptions of executive leadership and their commitment to health equity. From the view of middle management, the hiring of a Chief Diversity Officer or an Health Equity Officer within the organization signals a deliberate and proactive approach towards addressing equity issues. The middle managers express high hopes for these leaders, highlighting their instrumental role in driving change and reshaping organizational practices.

Indifferent or Negative Perceptions of Organizational and Executive Level Commitment

While some interviewees were optimistic about advancing health equity efforts within their organization, some expressed feelings of skepticism of negativity. Several participants viewed organizational efforts to advance health equity as a reactionary, disingenuous commitment towards improving the lives of the patients they serve. Additionally, they noted instances where the organization discussed embedding health equity into their business practice but failed to demonstrate tangible steps to realize these aspirations. For example, participants shared:

P11: "I would say there is consensus around the topic. It is important and there is an understanding of what health equity is. But, in terms of getting to how it is embedded in driving our work, I think that is a step that needs to be embarked on. We need to move beyond words. I feel like we all have heard "We're taking a lens of health equity" or "We are taking a lens of racial equity." What does that actually translate to?

> **P7: "** I think what we have not done to date… is really the health equity component. The ways in which we're understanding which populations need more investment…can we invest upstream further…Is there an advocacy component, is there more of a systemic or a structural investment we can make? There is work to do in this space"
>
> **P19:** "My hope is that we will see more buy-in from upper leadership, even the physicians and things like that, to understand even more why this work is important beyond the fact that it is a requirement, or beyond the fact that, oh, that seems like a really nice thing to do. That's what I'm hoping for."

These perspectives highlight a disconnect between organizational rhetoric and what middle managers are experiencing on the job. While there is recognition of the importance of health equity and discussions about embedding it into organizational practices, interviewees express a need for concrete steps to translate these intentions into meaningful outcomes. The lack of clarity on how health equity is integrated into day-to-day operations and decision-making processes suggests a gap between organizational aspirations and practical implementation. One participant makes a suggestion for how to do this:

> **P8:** "I want us and our team to tell a fuller, more true story of health and wellbeing than had been told previously. This means examining *every step* of how we initiate engagement with patients and getting input start to finish. We need to think about more inclusively in the ways that we work."

While another suggests that organizations start to be more intentional about discussing the role of race and racism in healthcare:

> **P17:** " I love working in healthcare, but people get real uncomfortable when you start talking about racism and race and equity. I think that's something that we need to continue to work through."

Perceptions of Individual Commitment to Health Equity

When we shift to looking at how middle managers view their own participation in the work, as people are actively engaged in advancing health equity within their organizations, most interviewees were positive about their ability to make an impact within the communities they serve. One positively described the work they are doing to understand how other hospitals are investing in health equity work:

> **P20:** "I'm currently conducting a landscape assessment to understand how our peer hospitals are investing in this work, the level of leadership engagement, and knowledge of community benefit. Additionally, I'm exploring how hospitals are focusing on leading from the intention of health equity and addressing disparities with our community benefit investments and processes, which aligns with your project's interests."

While others state that they have been doing health equity work long before health equity became a "buzzword" and the new shift in how organizations view the work has left them somewhat unclear about their job function and how to apply health equity frameworks:

> **P16:** "Health equity is not new. Especially again, those of us who've worked in community benefit and community health, we've spoken about it for years, many, many years, and I sort of joke, but not joke, I could go back in time to many board meetings where I was presenting, findings from our community health needs assessment that were specifically drawing upon health disparities …so again, that's not something new to us…COVID obviously has really elevated it.. in terms of bringing it more to the forefront, so yeah, you would think that there would be potentially more established frameworks out there that we could be using, but I'm not aware of it or how to use them as a manager."

Description of Health Equity Strategy

Middle managers provided insights into the processes and factors informing their healthcare organization's health equity strategy. One manager highlighted the importance of inclusion and relationship-building with marginalized communities, noting a lack of representation for groups such as

the Abenaki community in strategic discussions. They emphasized the need for intentionally in storytelling and honoring diverse narratives to foster mutually beneficial relationships over time:

> **P5:** "I was not a part of strategic conversations. But, what really stood out to me was the lack of inclusion for a lot of different communities.. I did not see proper representation on our steering committee, the working groups, the key informant interviews, etcetera. So, I wrote notes.. we don't have a relationship in a way that would be mutually beneficial over time with many marginalized communities to improve community health. I want us to be really intentionally about storytelling and the opportunity to honor people's stories."

Another manager reflected on a shift in language towards equity within their organization's documents, indicating that incorporating equity-centered language is a relatively new endeavor for their organization:

> **P1**: "Traditionally we haven't actually used the equity language as much as we've used language. So in this document we talk about recognizing cultural diversity, valuing strengths and assets, working mutually, respect and cultural awareness, approaching communities we serve with sensitivity. Those are the kinds of words that have been used, that are embedded in this. So not... I just, I have to say that we have not, until recently, really used the equity language."

Additionally, the adoption of new standards by accrediting bodies, such as the Joint Commission, was highlighted as a catalyst for health equity initiatives within healthcare systems. These standards emphasize data collection, analysis, and action to address inequities:

> **P18: "**The joint commission now has released a new set of standards, so most hospitals are accredited by the Joint Commission that are focused on health equity. So exactly that.
>
> > How are you collecting data? What are you doing with that data?... I think many health systems across the country are looking and trying to get it all together because now this is the time. I feel like that's... To your point, it seems like, why wouldn't we just look at the

patient data? I just, I think it just... I don't know why, it just wasn't discussed. I don't know. It's unfortunate."

Resources - Monetary Support or People-Support (i.e., Staff)

Nearly all of the participants highlighted the importance of resources, both financial and staff, in their efforts to advance health equity. Their insights revealed a multifaceted perspective on the challenges and opportunities within their respective organizations to become better resourced. One participant highlighted the significance of timing, leadership support, and available resources, emphasizing that these factors collectively enabled them to advance health equity initiatives effectively:

> **P11:** "So I think having that context and experience and then coming into an environment like it, it was the right time and I was lucky to have that leadership support and the resources to do that. And I will say some of the other hospitals in our system haven't engaged as deeply from this lens of health equity. I think a lot of that has to do with well valuing and seeing the value in this work, but also resources. Our Medical Center has set a precedent over the past several cycles of investing in consultants and having a budget carved out."

This quote demonstrates the importance of institutional commitment to health equity, evidenced by financial investment in consultants and budget allocations. The participant contrasts their experience with other hospitals in the system, suggesting that these differences in engagement levels may stem from varying degrees of resource allocation and perceived value of health equity work. This points to a broader systemic issue where the prioritization of health equity can vary significantly between institutions, influenced heavily by available resources and leadership vision. Another participant pointed to the role of leadership diversity in driving health equity efforts, particularly in rural communities where a lack of diversity can impede progress:

> **P14:** "I think it's having diverse leadership. I think when I look at a lot of these hospitals in some of these rural communities, not to dismiss my colleagues, there isn't diversity on the

boards. There isn't diversity in their leadership and I think oftentimes in healthcare, I've noticed, I'm newer to the sector, but clinicians, MDs, especially White men in a lot of instances climb to the top of the ladder."

This perspective highlights a critical barrier to health equity: the lack of diversity in leadership positions. The participant observes that predominantly White, male leadership can result in a narrow perspective on health equity issues, potentially overlooking the needs of diverse populations. This suggests that improving leadership diversity is crucial for fostering a deeper understanding and commitment to health equity.

Organizational Approaches to Measuring Health Equity Goals

The participants provided detailed insights into their organizations' approaches to measuring health equity goals, highlighting both the progress made and the areas needing further development. Their perspectives reveal a complex interplay of qualitative and quantitative methods, the evolution of data disaggregation practices, and the integration of social determinants of health assessments.

One participant described the foundational conversations and community involvement in the Community Health Needs Assessment (CHNA) process, which played a crucial role in identifying and eliminating health disparities:

P7: "So I think to answer your question, it was qualitative and then our process, which I can speak to our methods, but like really further, like illuminated those themes that we heard anecdotally. But we didn't have from the last assessment baseline data that was disaggregated. And so we knew that was a big intention of our assessment this cycle. And we heard that from stakeholders. You know that it's... There were many indicators that partners didn't have that the hospital didn't have. And so that was a big part of our process

with the secondary data and the primary data we collected to try to make that as granular as possible to highlight those disparities and those assets across different communities."

The initial qualitative discussions were instrumental in building trust and identifying key themes, which then informed the subsequent quantitative efforts to disaggregate data. This approach reflects a growing recognition of the need for detailed, disaggregated data to highlight specific disparities and resources within different communities, addressing a significant gap from previous assessments.

Another participant highlighted the historical lack of an evaluation plan and the recent efforts to address this gap through intentional data collection and resource allocation:

> **P9:** "I don't think we have historically, we don't have... We haven't had an evaluation plan in place and I would love to see us to move the needle in that way and that's what we've been hoping with this new process that we have that disaggregated data and we're thinking really intentionally about equity about those populations that are disproportionately affected and allocating our resources in that way."

This reflection reveals a critical organizational challenge: the absence of a structured evaluation plan for health equity goals. The participant expressed a desire for progress, indicating that the new processes involving disaggregated data collection represent a significant step forward. By focusing on populations that are disproportionately affected and aligning resources accordingly, the organization aims to create a more targeted and effective approach to advancing health equity.

A third participant described a specific initiative aimed at assessing social determinants of health (SDOH) needs annually for all patients, highlighting the use of a dashboard to monitor progress:

> **P15:** "So one of the initiatives that we are putting forward in collaboration with other leaders is the ability to assess social determinants of health needs of every patient that goes to our system at least once a year. So primarily for food, housing, and transportation. We

> have a dashboard whereby we monitor what's the percent of patients who have an assessment of social determinants of health during this time for example October, November, December and somehow we progress, and essentially the goal is, towards closing to 100% that they are assessed because the assessment is key. And then, talking with the patient is another as it relates to these needs and then the referral and the linkages to community and resources and all that."

This initiative represents a systematic approach to addressing SDOH, emphasizing regular assessments and the use of data to drive improvements. The dashboard serves as a critical tool for tracking the percentage of patients assessed and ensuring that nearly all patients undergo this important evaluation.

3.6 Discussion

As part of organizational efforts to address health equity, hospitals are utilizing middle managers to plan, design, and implement health equity-focused programs. However, there is variation across health systems in how middle managers perceive these efforts and their impact on populations and communities affected by the longstanding effects of structural racism. This study analyzed 20 interviews with healthcare leaders in middle management roles to understand their perceptions of their organizations' efforts to advance health equity. The goals were to describe middle managers' views on organizational commitment to health equity initiatives, analyze the strategies they use to overcome barriers and promote health equity, and identify the benefits and challenges they face in implementing these strategies within their departments.

Unlike the findings in Chapter 3, which examined Black executive leaders in Chief Diversity, Equity, and Inclusion or Chief Health Equity Officer roles and found an overwhelming sense of dissatisfaction and lack of support, this study found that middle managers had a more mixed outlook. Participants did acknowledge that their systems have: 1) difficulties discussing race, 2) fear it may privilege one group over others in need, 3) difficulty discussing how race and racism affect program

design and resource allocation. In these cases, health systems often default to a colorblind focus on poverty, understanding that there may be enough overlap between poverty-stricken communities and racial marginalization to compensate for their race-neutral stance.

Despite these challenges, many middle managers expressed confidence in their organization's commitment to promoting racial equity. They cited examples such as acknowledging racism as a public health issue and supporting racial equity-focused initiatives. Middle managers who discussed their executive leadership team often talked about their leaders with great confidence. They would often say that the introduction of a Chief Diversity Officer or a Chief Health Equity Officer was a step in the right direction, and they are excited to do more meaningful work under their leadership. This stands in stark contrast to the findings in Chapter 3, where Black executive leaders documented feelings of anger and frustration, insufficient budget and staff support, censorship by their organization, and a lack of understanding from their leadership regarding their roles. These leaders often felt pressured to achieve significant results without adequate resources.

It is likely that middle managers' generally positive outlook towards their organizations' progress, despite acknowledging the need for more work, is influenced by their position within the organization. Their hierarchical position allows them to have a brighter outlook on the future, supported by their confidence in executive leadership and their personal commitment to the work. They find fulfillment in their roles and lean on their leaders to drive change. In contrast, executive leaders in Chapter 3 do not have "aspirational leaders" to look up to, as they are situated in the C-suite and often feel isolated and treated as outsiders by their peers.

These findings reinforce other literature suggesting that an employee's position in the organizational hierarchy is a crucial, albeit often overlooked, factor. Employees at the top of the hierarchy have a perspective that spans multiple organizations, making them more critical of organizational efforts. This is further compounded by their race and ethnicity, as the literature shows that Black workers at the

top are more attuned to how discrimination impacts their job functions and operates within social structures (Wingfield, 2020). Meanwhile, those lower in the hierarchy are more likely to view efforts to advance health equity as a function of individual investment and have increased confidence in the organization. This may be because they do not have access to higher-order decision-making processes that would reveal more structural issues related to health equity strategic planning and development.

This also aligns with other work that has found that US workers largely overestimate the progress made toward racial equity in organizational representation (Torrez, Hollie, Richeson, & Kraus, 2024). In the study by Torrez and colleagues, they find that workers are generally positive when considering training policies (e.g., racial bias training), organizational statements, and targeted recruitment efforts. My findings align with this paper's sentiment that the pervasiveness of racial progress narrative shaping US workers' understanding of the effectiveness of DEI policies, even those that are relatively ineffective, deserves further inquiry. My paper takes this a step further by looking at health equity, and trying to see if similar sentiments of organizational progress are shared when speaking to middle managers about progress towards providing employees and patients with a fair chance at achieving their optimal health.

Avenues for Future Research

While this study provides valuable insights into middle managers' perceptions of organizational efforts to advance health equity, several avenues for future research remain unexplored and warrant further investigation.

The Role of Race in Perception of Organizational Progress

One significant limitation of this study is the lack of consideration given to the role of race in shaping middle managers' perceptions of organizational success in advancing health equity. Future research should delve into how racial identity influences these perceptions. There are a myriad of studies that show that Black employees, in particular, feel uncomfortable at work and lack trust in their superiors and the organizational overall (Opara, Sealy, & Ryan, 2020; Rabelo, Robotham, McCluney, 2020; Smith & Joseph, 2010; Everett & Hamilton-Mason, 2011; Alleyne, 2006). More than 35% of African-

Americans and Hispanics, as well as 45% of Asians, say they "need to compromise their authenticity" to conform to their company's standards of demeanor or style. Forty percent of African-Americans — and a third of people of color overall — feel like outsiders in their corporate culture, compared with 26% of Caucasians (Hewlett, 2012). A consideration of race and ethnicity can reveal whether middle managers from different racial and ethnic backgrounds have varied experiences and viewpoints regarding the effectiveness of health equity strategic efforts.

Reporting Structure and Contextual Influences

Another critical area for future research is the exploration of the reporting structures and the broader context in which middle managers operate. The reporting structure within an organization can significantly impact middle managers with their direct reports, if they have any, as well as their leadership. It can influence their level of involvement in strategic decision-making, their access to pertinent information such as health equity strategic developments, and their overall treatment within the organization. Future studies should investigate how different reporting hierarchies and organizational contexts affect middle managers' engagement with health equity initiatives. This could involve examining the degree of proximity middle managers have to senior leadership and strategic planning processes, as well as how these relationships influence their perceptions and effectiveness in promoting health equity.

Strengths and Limitations of the Research

This research offers several strengths, primarily due to its qualitative approach, which provides a nuanced understanding of the roles and perceptions of middle managers regarding health equity within organizations. By analyzing in-depth interviews, the study captures detailed insights into how middle managers perceive their responsibilities, the challenges they face, and the impact of their actions on advancing health equity. This in-depth exploration fills a critical gap in the literature, as middle managers' perspectives are often underrepresented. Their experiences are crucial for understanding the implementation and sustainability of health equity initiatives, making this research a valuable contribution to the field.

However, the study also has some limitations. One significant constraint is that the race of the interviewees was not recorded, which could impact the depth of the analysis regarding how racial identity might influence their experiences and perceptions. Understanding the racial background of participants could provide additional context and reveal specific challenges faced by different racial groups. Additionally, the relatively small sample size limits the generalizability of the findings. While the qualitative approach allows for rich, detailed insights, the small number of participants may not fully represent the diverse experiences of all middle managers within organizations.

Practical Implications and Recommendations for Executive Leaders

To address the issue of ambivalence and inaction among middle managers with health equity roles, executive leaders must take proactive steps to provide clear guidance, support, and motivation. Here are several concrete recommendations for executive leaders to help middle managers overcome feelings of uncertainty and drive effective health equity initiatives:

1. **Clarify Objectives and Provide Actionable Guidance:** Executive leaders should establish clear, specific objectives for health equity initiatives and provide actionable guidance to middle managers. By defining what success looks like and outlining concrete steps to achieve these goals, leaders can reduce ambiguity and empower managers to take decisive action. For example, setting quarterly targets for diversity in hiring practices or specific milestones for implementing equity training programs can provide middle managers with clear benchmarks to strive for.
2. **Facilitate Regular Communication and Feedback:** Leaders should create regular opportunities for middle managers to communicate their challenges and progress regarding health equity efforts. Implementing structured feedback mechanisms, such as monthly check-in meetings or feedback surveys, can help managers express concerns and seek advice. For instance, holding a monthly roundtable where managers can share their experiences and receive input from peers and executives can foster a supportive environment and address any emerging issues promptly.
3. **Invest in Targeted Training and Resources:** Providing targeted training and resources is crucial for equipping middle managers with the skills and knowledge needed to advance health equity

effectively. Executive leaders should ensure that training programs address practical skills for implementing health equity strategies, managing diverse teams, and navigating organizational barriers. For example, offering workshops on bias mitigation techniques or providing access to resources like equity toolkits can enhance managers' capabilities and confidence in their roles.

4. **Encourage and Model Commitment to Equity:** Leaders should model a strong commitment to health equity by actively participating in and endorsing equity initiatives. By visibly supporting and prioritizing these efforts, executives can reinforce the importance of health equity and motivate middle managers to remain engaged. For instance, executives can publicly celebrate successes in health equity or participate in initiatives themselves, demonstrating a genuine commitment to the organization's equity goals.
5. **Provide Support and Remove Barriers:** Executive leaders should work to identify and remove barriers that hinder middle managers from effectively advancing health equity. This may involve streamlining processes, allocating sufficient resources, or addressing systemic issues within the organization. For example, if managers face challenges in obtaining necessary data for tracking equity outcomes, leaders can work to improve data accessibility and support data-driven decision-making.
6. **Recognize and Reward Efforts:** Recognizing and rewarding the contributions of middle managers who successfully advance health equity can reinforce their commitment and motivation. Implementing recognition programs, such as awards for outstanding equity initiatives or incentives tied to achieving health equity milestones, can encourage continued investment in these efforts. For instance, creating an annual equity excellence award for managers who demonstrate exceptional progress in advancing equity can highlight their achievements and inspire others.

By taking these steps, executive leaders can address the ambivalence and inaction among middle managers, foster a more supportive environment, and drive meaningful progress in health equity

initiatives. Providing clear guidance, facilitating communication, investing in training, modeling commitment, removing barriers, and recognizing efforts are key strategies to ensure that middle managers are empowered and motivated to contribute effectively to the organization's equity goals.

Conclusion

Achieving health equity within organizations requires a critical acknowledgment of the limited progress made towards organizational equity and the considerable effort needed to provide both employees and patients with equitable opportunities for optimal health. Despite this reality, there is a prevailing belief among middle managers that progress is being made towards advancing health equity and organizational diversity. However, the outcomes of these efforts may not be realized for several decades. This paper suggests that the commitment to advancing health equity within organizations often reflects the inherent tendency of organizations to create hierarchies. Additionally, it may be indicative of executive leaders shielding their teams from critical information in an attempt to maintain momentum and positivity.

I argue that when middle managers are uncertain about how to advance health equity, they often become "ambivalent" and consequently end up doing "nothing." This inaction is detrimental to future efforts to create a more equitable, just, and anti-racist workplace. To ensure that middle managers continue to invest time, effort, and resources into advancing health equity, executive leaders must provide clearer guidance on actionable steps and demonstrate how these efforts can lead to tangible outcomes. Without this support, the potential for meaningful progress towards a more equitable organizational culture remains compromised.

REFERENCES

Alleyne, A. (2006). Black identity and workplace oppression. *Counselling and Psychotherapy Research*, *4*(1), 4–8. https://doi.org/10.1080/14733140412331384008

Arthur, M. B., & Rousseau, D. M. (2001). *The Boundaryless Career: A New Employment Principle for a New Organizational Era*. Oxford University Press.

Baker, G. R. (2001). Healthcare managers in the complex world of healthcare. *Frontiers of Health Services Management*, *18*(2), 23–32.

Belasen, A., & Belasen, A. (2016). Value in the Middle: Cultivating Middle Managers in Healthcare Organizations. *Journal of Management Development*, *35*, 1149–1162. https://doi.org/10.1108/JMD-12-2015-0173

Bendix, R. (1963). *Work and Authority in Industry: Ideologies of Management in the Course of Industrialization*. Harper & Row.

Birken, S. A., DiMartino, L. D., Kirk, M. A., Lee, S.-Y. D., McClelland, M., & Albert, N. M. (2016). Elaborating on theory with middle managers' experience implementing healthcare innovations in practice. *Implementation Science*, *11*(1), 2. https://doi.org/10.1186/s13012-015-0362-6

Birken, S. A., Lee, S.-Y. D., & Weiner, B. J. (2012a). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science : IS*, *7*, 28. https://doi.org/10.1186/1748-5908-7-28

Birken, S. A., Lee, S.-Y. D., & Weiner, B. J. (2012b). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science : IS*, *7*, 28. https://doi.org/10.1186/1748-5908-7-28

Bond, M. J., & Herman, A. A. (2016). Lagging Life Expectancy for Black Men: A Public Health Imperative. *American Journal of Public Health*, *106*(7), 1167–1169. https://doi.org/10.2105/AJPH.2016.303251

Borsky, A., Zhan, C., Miller, T., Ngo-Metzger, Q., Bierman, A. S., & Meyers, D. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. *Health Affairs*, *37*(6), 925–928. https://doi.org/10.1377/hlthaff.2017.1248

Brown, R. H. (1978). Bureaucracy as Praxis: Toward a Political Phenomenology of Formal Organizations. *Administrative Science Quarterly*, *23*(3), 365–382. https://doi.org/10.2307/2392415

Buchanan, D. A., Denyer, D., Jaina, J., Kelliher, C., Moore, C., Parry, E., & Pilbeam, C. (2013). The realities of middle management. In *How do they manage? A qualitative study of the realities of middle and front-line management work in health care*. NIHR Journals Library. https://www.ncbi.nlm.nih.gov/books/NBK259391/

Burns, T. (1957). Management in Action. *Journal of the Operational Research Society*, *8*(2), 45–60. https://doi.org/10.1057/jors.1957.7

Cameron, K. S., & Whetten, D. A. (1981). Perceptions of Organizational Effectiveness Over Organizational Life Cycles. *Administrative Science Quarterly*, *26*(4), 525–544. https://doi.org/10.2307/2392338

Campbell, E. G., Singer, S., Kitch, B. T., Iezzoni, L. I., & Meyer, G. S. (2010). Patient safety climate in hospitals: Act locally on variation across units. *Joint Commission Journal on Quality and Patient Safety*, *36*(7), 319–326. https://doi.org/10.1016/s1553-7250(10)36048-x

Chuang, E., Jason, K., & Morgan, J. C. (2011). Implementing complex innovations: Factors influencing middle manager support. *Health Care Management Review*, *36*(4), 369–379. https://doi.org/10.1097/HMR.0b013e3182100cc2

Dolan, T. C. (2013). Increasing diversity in governance and management. *Journal of Healthcare Management / American College of Healthcare Executives*, *58*(2), 84–86.

Embertson, M. K. (2006). The Importance of Middle Managers in Healthcare Organizations. *Journal of Healthcare Management*, *51*(4), 223–232.

Engle, R. L., Lopez, E. R., Gormley, K. E., Chan, J. A., Charns, M. P., & Lukas, C. V. (2017). What roles do middle managers play in implementation of innovative practices? *Health Care Management Review*, *42*(1), 14–27. https://doi.org/10.1097/HMR.0000000000000090

Federico, F., & Bonacum, D. (2010). Strengthening the core. Middle managers play a vital role in improving safety. *Healthcare Executive*, *25*(1), 68–70.

Feifer, C., & Ornstein, S. M. (2004). Strategies for Increasing Adherence to Clinical Guidelines and Improving Patient Outcomes in Small Primary Care Practices. *The Joint Commission Journal on Quality and Safety*, *30*(8), 432–441. https://doi.org/10.1016/S1549-3741(04)30049-3

Field, E., Hancock, B., & Mugayar-Baldocchi, M. (n.d.). *Middle management: A precious but wasted resource | McKinsey*. Retrieved April 17, 2024, from https://www.mckinsey.com/capabilities/people-and-organizational-performance/our-insights/stop-wasting-your-most-precious-resource-middle-managers

Field, E., Hancock, B., & Schaninger, B. (2023, July 1). Don't Eliminate Your Middle Managers. *Harvard Business Review*. https://hbr.org/2023/07/dont-eliminate-your-middle-managers

Field, E., Hancock, B., & Schaninger, B. (2024, April 17). *How to be a good middle manager | McKinsey*. McKinsey & Company. https://www.mckinsey.com/featured-insights/mckinsey-on-books/author-talks-what-does-it-mean-to-be-a-good-middle-manager

Gjerde, S., & Alvesson, M. (2020). Sandwiched: Exploring role and identity of middle managers in the genuine middle. *Human Relations*, *73*(1), 124–151. https://doi.org/10.1177/0018726718823243

Greenwald, A. G., Dasgupta, N., Dovidio, J. F., Kang, J., Moss-Racusin, C. A., & Teachman, B. A. (2022). Implicit-Bias Remedies: Treating Discriminatory Bias as a Public-Health Problem. *Psychological Science in the Public Interest*, *23*(1), 7–40. https://doi.org/10.1177/15291006211070781

Hagedorn, H., Hogan, M., Smith, J. L., Bowman, C., Curran, G. M., Espadas, D., Kimmel, B., Kochevar, L., Legro, M. W., & Sales, A. E. (2006). Lessons Learned about Implementing Research Evidence into Clinical Practice: Experiences from VA QUERI. *Journal of General Internal Medicine*, *21*(Suppl 2), S21–S24. https://doi.org/10.1111/j.1525-1497.2006.00358.x

Hewlett, S. A. (2012, October 18). Too Many People of Color Feel Uncomfortable at Work. *Harvard Business Review*. https://hbr.org/2012/10/too-many-people-of-color-feel

Himmelstein, G., Ceasar, J. N., & Himmelstein, K. E. (2023). Hospitals That Serve Many Black Patients Have Lower Revenues and Profits: Structural Racism in Hospital Financing. *Journal of General Internal Medicine*, *38*(3), 586–591. https://doi.org/10.1007/s11606-022-07562-w

Huy, Q. N., & Osterman, P. (2010). The Truth about Middle Managers: Who They Are, How They Work, and Why They Matter. *Administrative Science Quarterly*, *55*(1), 167–169. https://doi.org/10.2189/asqu.2010.55.1.167

Implementing strategic change in a health care system: The i... : Health Care Management Review. (n.d.). Retrieved April 30, 2024, from https://journals.lww.com/hcmrjournal/fulltext/2008/04000/implementing_strategic_change_in_a_hea

lth_care.5.aspx?casa_token=ZhJ5N0973fwAAAAA:rCZ01ItgLlsMKPaI3v8I6sXJKjpaSuj18GBrElau9Erhuf7doTOIapklwBiSKGI1MtEqgoXad9emnOSM3Z6Gs84q8Dm9

Jaser, Z. (2021). The Real Value of Middle Managers. *Harvard Business Review*. https://hbr.org/2021/06/the-real-value-of-middle-managers

Jean, P. L. (2024). *Strategically Navigating Anti-Black Racism in Professional Spaces: A Practical Guide for Black People Responding to Racism in the Workplace*. New Harbinger Publications.

Kayser, A. (2024, March 15). *Middle management's shaky future*. https://www.beckershospitalreview.com/hospital-management-administration/middle-managements-shaky-future.html

Khaw, K. W., Alnoor, A., AL-Abrrow, H., Tiberius, V., Ganesan, Y., & Atshan, N. A. (2023). Reactions towards organizational change: A systematic literature review. *Current Psychology*, *42*(22), 19137–19160. https://doi.org/10.1007/s12144-022-03070-6

Kotter, J. P. (1982). What effective general managers really do. *Harvard Business Review*, *60*(6), 156–167.

Kras, K. R., Portillo, S., & Taxman, F. S. (2017). Managing from the Middle: Frontline Supervisors and Perceptions of Their Organizational Power. *Law & Policy*, *39*(3), 215–236. https://doi.org/10.1111/lapo.12079

Lynch, J. J., & Rogers, V. L. (1986). Role conflict and role ambiguity among middle managers in general acute care hospitals. *Journal of Allied Health*, *15*(2), 115–128.

Mahajan, S., Caraballo, C., Lu, Y., Valero-Elizondo, J., Massey, D., Annapureddy, A. R., Roy, B., Riley, C., Murugiah, K., Onuma, O., Nunez-Smith, M., Forman, H. P., Nasir, K., Herrin, J., & Krumholz, H. M. (2021). Trends in Differences in Health Status and Health Care Access and Affordability by Race and Ethnicity in the United States, 1999-2018. *JAMA*, *326*(7), 637–648. https://doi.org/10.1001/jama.2021.9907

McConnell, C. R. (2005). Larger, smaller, and flatter: The evolution of the modern health care organization. *The Health Care Manager*, *24*(2), 177–188. https://doi.org/10.1097/00126450-200504000-00011

Melaku, T. M., & Winkler, C. (2022). Are Your Organization's DEI Efforts Superficial or Structural? *Harvard Business Review*. https://hbr.org/2022/06/are-your-organizations-dei-efforts-superficial-or-structural

Mills, C. W. (1951). *White Collar: The American Middle Classes*. Oxford University Press.

Mintzberg, H. (1989). Inside Our Strange World Of Organizations. *Organization Studies*, *11*(4), 599–599. https://doi.org/10.1177/017084069001100414

National Academies of Sciences, E., Division, H. and M., Practice, B. on P. H. and P. H., States, C. on C.-B. S. to P. H. E. in the U., Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). The State of Health Disparities in the United States. In *Communities in Action: Pathways to Health Equity*. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK425844/

Njoku, A., Evans, M., Nimo-Sefah, L., & Bailey, J. (2023). Listen to the Whispers before They Become Screams: Addressing Black Maternal Morbidity and Mortality in the United States. *Healthcare*, *11*(3), 438. https://doi.org/10.3390/healthcare11030438

Noble, C. H. (1999). The Eclectic Roots of Strategy Implementation Research. *Journal of Business Research*, *45*(2), 119–134. https://doi.org/10.1016/S0148-2963(97)00231-2

Okunrintemi, V., Valero-Elizondo, J., Patrick, B., Salami, J., Tibuakuu, M., Ahmad, S., Ogunmoroti, O., Mahajan, S., Khan, S. U., Gulati, M., Nasir, K., & Michos, E. D. (2018). Gender Differences in Patient-Reported Outcomes Among Adults With Atherosclerotic Cardiovascular Disease. *Journal of the American Heart Association*, *7*(24), e010498. https://doi.org/10.1161/JAHA.118.010498

Opara, V., Sealy, R., & Ryan, M. K. (2020). The workplace experiences of BAME professional women: Understanding experiences at the intersection. *Gender, Work & Organization*, *27*(6), 1192–1213. https://doi.org/10.1111/gwao.12456

Plsek, P. E., & Wilson, T. (2001). Complexity, leadership, and management in healthcare organisations. *BMJ : British Medical Journal*, *323*(7315), 746–749.

Rabelo, V. C., Robotham, K. J., & McCluney, C. L. (2021). "Against a sharp white background": How Black women experience the white gaze at work. *Gender, Work & Organization*, *28*(5), 1840–1858. https://doi.org/10.1111/gwao.12564

Raths, D. (2020, May 20). *Chief Equity Officers Become Critical Members of the C-Suite*. Healthcare Innovation. https://www.hcinnovationgroup.com/policy-value-based-care/c-suite-innovators/article/21138574/chief-equity-officers-become-critical-members-of-the-c-suite

Ray, V. (2019a). A Theory of Racialized Organizations. *American Sociological Review*, *84*(1), 26–53. https://doi.org/10.1177/0003122418822335

Ray, V. (2019b). A Theory of Racialized Organizations. *American Sociological Review*, *84*(1), 26–53. https://doi.org/10.1177/0003122418822335

Raza, M. A., Imran, M., Rosak-Szyrocka, J., Vasa, L., & Hadi, N. U. (2023). Organizational Change and Workplace Incivility: Mediated by Stress, Moderated by Emotional Exhaustion. *International Journal of Environmental Research and Public Health*, *20*(3), Article 3. https://doi.org/10.3390/ijerph20032008

Rovella, D. (n.d.). Middle Managers Are Getting Fired More Often. *Bloomberg*. Retrieved April 17, 2024, from https://www.bloomberg.com/news/newsletters/2024-03-15/bloomberg-evening-briefing-middle-managers-are-getting-fired-more-often

Samreen, F., Nagi, S., Naseem, R., & Gul, H. (2022). COVID-19-Induced Downsizing and Survivors' Syndrome: The Moderating Role of Transformational Leadership. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.833116

Taylor, S. E., & Fiske, S. T. (1978). *Salience, Attention, and Attribution: Top of the Head Phenomena* (L. Berkowitz, Ed.; Vol. 11, pp. 249–288). Academic Press. https://doi.org/10.1016/S0065-2601(08)60009-X

Uehling, M., Hall-Clifford, R., Kinnard, C., & Wimberly, Y. (2023). Advancing Equity in U.S. Hospital Systems: Employee Understandings of Health Equity and Steps for Improvement. *Journal of Healthcare Management*, *68*(5), 342–355. https://doi.org/10.1097/JHM-D-22-00187

Watkins, M. (n.d.). *How Managers Become Leaders*. Harvard Business Review. Retrieved April 17, 2024, from https://hbr.org/2012/06/how-managers-become-leaders

Weber, M. (1978). *Economy and Society: An Outline of Interpretive Sociology*. University of California Press.

Weber, P. S., & Weber, J. E. (2001). Changes in employee perceptions during organizational change. *Leadership & Organization Development Journal*, *22*(6), 291–300. https://doi.org/10.1108/01437730110403222

Wingfield, A. H., & Alston, R. S. (2014). Maintaining Hierarchies in Predominantly White Organizations: A Theory of Racial Tasks. *American Behavioral Scientist*, *58*(2), 274–287. https://doi.org/10.1177/0002764213503329

Witt Smith, J., & Joseph, S. E. (2010). Workplace challenges in corporate America: Differences in black and white. *Equality, Diversity and Inclusion: An International Journal*, *29*(8), 743–765. https://doi.org/10.1108/02610151011089500

Wooten, M., & Couloute, L. (2017). The production of racial inequality within and among organizations: Organizational Inequality. *Sociology Compass*, *11*, e12446. https://doi.org/10.1111/soc4.12446

Yearby, R. (2020). Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause. *Journal of Law, Medicine & Ethics*, *48*(3), 518–526. https://doi.org/10.1177/1073110520958876

Zaleznik, A. (2004). Managers and Leaders: Are They Different? *Harvard Business Review*. https://hbr.org/2004/01/managers-and-leaders-are-they-different

Zhang, L. (2023). The Changing Role of Managers. *American Journal of Sociology*, *129*(2), 439–484. https://doi.org/10.1086/727145

Chapter 4 "I Started from Zero": How Black Executive Leaders Advance Health Equity and DEI Efforts within Racialized Organizations

4.1 Background

In 2020, companies all over the United States issued bold commitments to diversity, equity, and inclusion (DEI) and advancing health equity. The murder of George Floyd elevated global consciousness around DEI to new heights and sparked what has been termed "the largest movement in U.S. history" (Buchanan et al., 2020; Corley, Pamphile, & Sawyer, 2022). In the corporate world, employees and customers demanded that companies make a greater commitment to racial justice, and leaders accelerated their efforts to address workplace inequities in response. That year, America's 50 biggest public companies and their foundations collectively committed at least $49.5 billion to address racial inequality, signifying an unparalleled financial commitment on a national scale (Jan, McGregor, & Hoyer, 2021). At the same time, the COVID-19 pandemic highlighted long standing health and social inequities in healthcare and raised the urgent question of how health equity can be achieved (Abbasi, 2020; Bambra Riordan, Ford, & Matthews, 2020; Johnson-Agbakwu et al., 2020; Kawachi, 2020; Gravlee 2020; Holden et al., 2022). Federal agencies, researchers, and advocates championed comprehensive health policy reform addressing factors contributing to social marginalization and poor health. Proposals ranged from expanding healthcare coverage and implementing value-based payment models to address social needs, to actively involving communities and historically marginalized populations in policy implementation and design. These reform efforts underscored the importance of formally recognizing health equity as the overarching goal while acknowledging structural racism as the root cause of health, economic, and social inequities (Sommers & Haffajee, 2021; Bleser et al., 2022; Moore et al., 2022).

Health systems responded to the heightened attention to health equity and demands to address racism in healthcare by elevating existing or creating new offices and roles related to diversity, inclusion,

belonging and health equity (Kayser, 2023). Individuals hired for these roles are often tasked with leading initiatives aimed at fostering inclusive workplace cultures or addressing disparities in health and healthcare. However, the literature indicates that Chief Diversity Officers (CDOs) and Health Equity (CHEOs) officers may not have been positioned for success, and the organizational backing for diversity, equity, and inclusion (DEI), in particular, appears to be diminishing. Across both public and private sectors, executives consistently point to insufficient institutional support, budget constraints, and challenges in career advancement (Goldstein, Grewal, Immose, & Williams, 2022). The average tenure of CDOs at large publicly-traded US firms dwindled to less than 2 years as of 2023 (Korn Ferry, 2023). We know even less about the average tenure of CHEO positions, but it is likely they face similar obstacles in securing long-term positions of influence.

Prevalence of Racial Disparities in Healthcare Leadership

This is troubling because researchers have consistently documented the widespread persistence of racism in the United States, leading to disparities for historically marginalized racial and ethnic groups across a broad spectrums of issues, from life expectancy to educational access to wealth access (Brown et al., 2003; Shapiro, 2004; Tyson, 2011). Hospitals, given their pivotal role in delivering health services, are uniquely positioned to address these inequities (Weissman et al., 2023). However, the lack of diversity in healthcare governing bodies and C-suites poses a significant challenge in effectively tackling racial disparities, particularly in hospital system leadership where data reveals a dominance of white individuals, men, and white males (Lee et al., 2021). A recent survey conducted by the American Hospital Association (2021) revealed that nearly 90% of hospital CEOs are white. The 2019 American Hospital Association (AHA) Health Care Governance Survey indicated minimal progress in both gender or ethnic minority board diversification, with reported figures of 87% white membership, 30% female membership, and 13% ethnic minority board membership (Manang, 2023). Until 2021, there was little change in the number of boards with ethnic minority representation, with a notable uptick likely in response to high-profile racial incidents and protests (Manag, 2023). Despite board leaders reporting they understand the benefits of DEI, they are largely “ready to move onto other topics” (Rappleye, 2019). This trend requires

attention, especially considering that board recruitment practices and organizational goals for DEI and health equity are often misaligned and racially diverse boards are more likely to engage in DEI and health equity practices than boards that lack people of color (Manang, 2023).

Further, there is a lack of reliable data on the demographics of the Chief Diversity Officer and Chief Health Equity Officer roles. One estimation claims that a staggering 76.1% of CDOs are white (Barger, 2023; Zippia, 2023), a statistic widely disseminated across professional social channels and explored in various think pieces (Nwanji, 2023; Brownlee, 2022). When considering the overall demographics of the U.S. labor force, a substantial percentage of available workers, and consequently those applying for DEI roles, are likely white. According to the Bureau of Labor Statistics, our labor force comprises 77% white, 13% Black, 7% Asian, 1% American Indians and Alaska Natives, and less than half a percent for Native Hawaiians and Other Pacific Islanders. However, another study conducted pre-pandemic by the Institute for Diversity in Health Management (an arm of the American Hospital Association) (2015) found that 77% of non-white executives own the “chief diversity officer” title. Though the exact percentage is unclear, the possible overrepresentation of white individuals in roles dedicated to uplifting historically marginalized voices raises concerns about perpetuating existing racial disparities in leadership. This disparity could perpetuate a cycle where the perspectives, needs, and experiences of marginalized communities continue to be overlooked, further entrenching the dominance of certain racial groups in positions of power and influence. Additionally, it may undermine efforts towards achieving true equity and inclusivity by hindering the emergence of diverse leadership that reflects and understands the complexities of diverse communities.

Additionally, executive position holders who lack exposure to diverse perspectives may develop “blind spots" related to racism and discrimination with organizations, which can perpetuate health disparities within the system and the communities it serves (Dotson, Bonam, & Jagers, 2017). Reliable statistics on the number and demographics of Chief Health Equity Officers in the United States remain unavailable due to the absence of a comprehensive list of these officers (Weissman et al., 2023). However, in the 2023 EY Health Equity Outlook Report, 98% healthcare companies state they have a

health equity strategy, 60% initiated the strategy in just the last five years, and 34% created it during the COVID-19 pandemic (Garfield, Aluko, Minta, Hildreth, & Kasen, 2023). The report also found that there is a high variation in health equity priorities, with no more than 20% of organizations indicating any given focus area as their top priority (Garfield, Aluko, Minta, Hildreth, & Kasen, 2023). In 2024, this trend may be shifting. According to a recent report by the Deloitte Center for Health Solutions (2024), over 80% of C-suite executives from healthcare and life sciences organizations consider health equity to be among their top 10 goals for 2024. Furthermore, 50% of respondents anticipate an increase in investments towards health equity initiatives this year.

In many hospitals, the emergence of roles dedicated to diversity, equity, and inclusion (DEI) and health equity reflected a growing awareness of the need to address systemic issues within healthcare organizations. It also represents an organizational response to societal demands to prioritize historically excluded populations and confront the legacy of racism within the United States healthcare system. Individuals occupying these positions are expected to serve as pivotal figures, assuming responsibilites as conveners, champions, thought leaders, and organizational resources for matters related to health equity or DEI. These roles, while novel, have quickly become crucial in shaping the organizational landscape of healthcare institutions.

The tasks associated with these roles are further complicated by the consistent conflation of DEI and health equity (see Figure 1). Diversity, equity, and inclusion (DEI) refer to a set of values and practices that aim to create a workplace, educational setting, or other environment where everyone feels valued, respected, and included, regardless of their race, ethnicity, gender, sexual orientation, religion, or other identity factors. The American Association of Medical Colleges (AAMC), for example, defines DEI as a practice that actively promotes and values diversity, eliminates discrimination and bias, and creates an inclusive environment that allows all individuals to thrive (AAMC, 2019). Health equity, on the other hand, refers to the idea that everyone has a fair and just opportunity to be as healthy as possible (Robert Wood Johnson Foundation., 2023). This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair

pay, quality education and housing, safe environments, and health care (Robert Wood Johnson Foundation, 2023).

Despite their common goals and the synergy between the two fields, it is crucial to recognize them as distinct but interrelated concepts. While our comprehension of DEI and health equity, and their impact on healthcare, is expanding, our understanding of the individuals responsible for these roles and their experiences is relatively limited (Hogan et al., 2022). Adding to our limited understanding is the scarcity of literature examining the leadership experiences of Black executive leaders serving in positions tasked with advancing DEI and health equity initiatives. Their unique professional experiences as Black leaders engaged in this work, along with their perceptions regarding organizational commitment to advancing health equity and Diversity, Equity, and Inclusion (DEI) efforts within hospitals, have remained largely unexplored. These leaders may offer insights into how organizational policies and practices—whether explicitly or implicitly—reproduce racial inequities (Yearby, 2000).

4.2 Theoretical Framing

How Race Influences Organizational Processes and Black Executive Leadership Success

For years, scholars of race and scholars of organizational theory have criticized the absence of a structural theory on race and organizations. Acker's (1990) and Nkomo's (1992) works called for scholars to move beyond contextualizing race as a demographic characteristic. Bonilla-Silva (1997) and Wooten (2017) have emphasized the need for a theory that engages with both the sociology of race and organizational theory. Wooten and Coulette (2017) argued that organizations can have an "identity," that allows them to be racialized similarly to the way that people are. As racialized spaces, organizational beliefs, rituals, norms, and language can reproduce inequalities. While Wooten and Coulette (2017) discuss the ways organizations can develop a racial identity, Victor Ray (2019) explains that organizations are not race neutral or meritocracies, but rather long-standing social structures designed and

managed to prioritize whiteness. By seeing organizations as racial structures, we can pay attention to fundamental sociological and organizational questions about power, structure, and agency.

Taking into account the scholarly insights into racialized organizations, it is important to consider how healthcare institutions may also be subject to racialization (Wingfield & Chavez, 2020). This racialization could significantly impact Black executive leaders tasked with implementing DEI and health equity strategies. While existing literature has predominantly examined professional programs like medical schools as racialized entities, evidence suggests that seemingly race-neutral processes and structures within medical education may reproduce and sustain racial inequality among medical trainees (Tiako, Ray, & South, 2022). For example, white students are more likely to enter medical school in the "doctor dynasty" where they can leverage social capital for opportunities, while racial stereotyping creates a hostile learning environment negatively impacting residency placement and career trajectories for students of color (Tiako, Ray, & South, 2022). However, there is a noticeable gap in understanding how race neutral processes and structures might affect the leadership experiences of executive leaders who identify as Black.

Healthcare systems have a long history of embedded assumptions about race, health, and medicine that reproduce racial inequalities within them (Hoberman, 2012). They may take on a racialized identity as "white spaces" through cultural and normative practices, such as stereotyping Black patients as noncompliant or downplaying their accounts of pain (Wingfield & Chavez, 2017). While most organizations no longer have explicitly racist goals, research shows they continue to function within a racialized social system that limits the emotional displays of Black employees (Wingfield, 2010), restricts the status of minority-serving organizations (Damaske, 2009), and segregates Black and White employees into different occupations (Stainback & Tomaskovic-Devey, 2012).

The current shift in scholars considering how race and racism becomes infused in everyday organizational, institutional, and market activities, and the processes that racialize organizations, is critical and must be acknowledged in the context of my research. Feagin (2006) contends that anti-Black racism is foundational to the United States, has been remarkably consistent over time, and is at the core of the

country's legal, economic, political, educational, and social systems. Contemporary organizational theories exploring both gendered and racialized organizations connect social hierarchies to the creation and operation of organizations, including hiring and promotion, training, leadership, and policies that legitimate the unequal distribution of resources within them (Ray, 2019). In this chapter, I explore how the ordinariness of racism (Ford, 2010) impacts the potential for Black executive leaders in DEI and health equity-focused roles to advance health equity and DEI strategy. Building upon the insights from racialized organizational literature, I extend the theory of racialized organizations by illustrating how race intersects with organizational and institutional processes, detrimentally affecting the career aspirations and leadership capabilities of Black executive leaders in roles related to diversity, equity, and inclusion (DEI) as well as health equity.

In this chapter, I offer three insights into how race influences the strategies adopted by organizations striving to demonstrate commitment to DEI and health equity. First, I emphasize that hospitals and healthcare systems strategic goals often serve merely as a facade for public consumption and gaining legitimacy, rather than facilitating the actual work Black executive leaders were hired to accomplish. Second, I explore how race governs the fundamental logics underpinning daily organizational operations. Specifically, I demonstrate how the practice of organizing work based on assumptions about racial and ethnic knowledge creates a scenario where Black executive leaders feel tokenized and hired solely because of their race. Lastly, I discuss how individuals' perception of race contributes to the perpetuation of colorblind policies and procedures within organizations, obscuring the systemic inequities and power dynamics that underlie racial disparities in executive leadership teams.

Race as a Fundamental Element in Organizations: Strategy, Process, and Institutional Logics

My chapter goals are structured into three distinct areas: how organizations treat race as strategy, race as process, and race as institutional logics. This categorization stems from the recognition that classical texts in organization theory have largely overlooked race. For instance, DiMaggio and Powell's (1991) *The New Institutionalism in Organizational Analysis* does not engage with race in any of its

selected articles. This absence persists in other seminal texts, such as W. Richard Scott's (2001) *Institutions and Organizations*, James March's *The Handbook of Organizations* (1965), and Howard Aldrich's (1999) *Evolving Organizations.* The recent acknowledgment that race is a crucial factor in the creation and operation of organizations, as well as in the implementation of institutional structures, represents a relatively new endeavor to systematically integrate race into organizational analysis (Ray, 2018; Ray & Purifoy, 2021; Rojas, 2017; Wooten & Couloute, 2017). Drawing on recent scholarship in this area, which contends that race should be considered a fundamental element of organizations, I explore how race and racism underpins organizational strategies to advance DEI and health equity efforts, informs institutional logics, and influences organizational processes (Wooten, 2019).

In the context of "race as strategy," organizations often strategically leverage race as a means of signaling their commitment to Diversity, Equity, and Inclusion (DEI) and health equity. This strategic maneuver aligns with the concept of conformism within organizational institutionalism, where adherence to prevailing norms secures access to vital resources (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). One notable manifestation of this strategy is the deliberate hiring of Black executive leaders, which serves as a tangible demonstration of organizational values and priorities. By appointing Black leaders, publicly elevating their roles, and emphasizing a dedication to DEI and health equity, organizations aim to position themselves as socially responsible entities responsive to broader societal and market pressures. However, this strategic positioning often masks underlying contradictions within organizational practices and norms, as highlighted by Ray and Purifoy (2019) in their examination of colorblind organizations.

Despite outward displays of commitment to diversity, Black workers continue to encounter systemic racial discrimination within the workplace. Studies reveal a pattern of selectively enforced rules, overt racial harassment, and disparities in promotions and job security faced by Black professionals (Mong and Roscigno, 2010; Lacy, 2007; Anderson, 1999). Even Black women, despite their qualifications and capabilities, encounter barriers such as difficulty finding white mentors or sponsors in predominantly white male environments (Bell and Nkomo, 2003; Melaku, 2019).The elevation of Black employees into high-powered positions, while seemingly a step towards inclusivity, often perpetuates the

idea that Black executives were hired for "strategic" (i.e.., performative) purposes. These roles, although appearing prestigious, are often less integrated into the organizational structure, offer limited long-term security, and provide fewer pathways to top management positions (Tomaskovic-Devey, 2012). Thus, while organizations may strategically deploy race to enhance their image and demonstrate their commitment to DEI and health equity, the lived experiences of Black workers reveal persistent disparities and structural obstacles that undermine the effectiveness of such initiatives.

Later in the chapter, I provide examples of "race as process," specifically showing how Black executive leaders encounter racism at work, navigate content-coded workplaces, and contend with corporate censorship regarding discussions about racism. This discussion helps to illustrate how race functions as a process, where whiteness as the norm enables such practices within organizations. This chapter also substantiates the claim that race infiltrates organizations and sustains racial inequality in workplaces. Research on race, work, and organizations indicates that assumptions regarding specialized knowledge contribute to racial inequality (Watkins-Hayes, 2009; Wingfield, 2009; Wingfield & Alston, 2014). Roles such as diversity officers and multicultural marketing teams often assign racialized labor, where Black executives are presumed uniquely suited to fulfill these roles (Collins, 1997). At the organizational level, policies, regulations, and norms may be written to be race neutral but ultimately have a disparate impact on Black workers - what is often referred to as organizational discrimination (Wingfield, 2020).

The concept of race as process closely aligns with the fundamental principles of critical race theory (CRT) (Delgado & Stefanic, 2001), wherein one of its central tenets posits that racism is both ordinary and pervasive (Ford, 2010). The everyday nature of racism suggests that individuals in positions of power or privilege (Rocco & Gallagher, 2004) often fail to recognize their attitudes or actions as racist, instead viewing them as normal, typical, and reflective of the status quo (Bowman, Rocco, Peterson, & Adker, 2009). In the context of Black executives navigating racism within organizations where whiteness is the norm, this working experience operates as intended. CRT asserts that "members of this country's dominant racial group cannot easily grasp what it is like to be nonwhite" (Bowman, Rocco, Peterson, &

Adker, 2009). In the context of this qualitative paper and within CRT, storytelling and amplifying Black voices become powerful tools, revealing the racist acts Black employees face daily while operating within seemingly race-neutral organizations. Moreover, the interpretation of experiences with racism varies significantly based on an individual's degree of power and authority within an organization. These perspectives closely align with the findings of this paper, demonstrating that Black executives experience racism differently from individuals at other levels of the organizational hierarchy (see Chapter 4), and are consistent with broader literature indicating a correlation between organizational hierarchies and perceptions of racial discrimination (Wingfield, 2020).

While utilizing the race of staff to address diversity-related concerns may seem advantageous, it also reinforces ethnoracial logics, suggesting that nonwhites should oversee occupations engaging with other nonwhites. Through my interviews, I reveal that race as a logic reproduces inequality, including the devaluation of job status when non-whites hold prominent positions (Banch & Wooten, 2012) and the restriction of career advancement of nonwhites (Stainback & Tomaskovic-Devey, 2012). By comparing the leadership experiences of Black executives, I aim to illustrate how race as logic affects the aspirations and career possibilities of Black professionals in DEI and health equity roles.

4.2 Objective

The current body of literature lacks a qualitative exploration of DEI and Health Equity Officers operating within racialized healthcare organizations. This gap underscores the need for an in-depth exploration of the specific responsibilities, strategic orientations, and challenges faced by Black professionals in these roles within racialized organizational contexts. This study aims to fill this gap by demonstrating how race intersects with organizational and institutional processes, detrimentally affecting the career aspirations and leadership capabilities of Black executive leaders in roles related to diversity, equity, and inclusion (DEI) as well as health equity.

Drawing from theories of racialized organizations, I substantiate my argument by showing how organizations activate race for strategic purposes (strategy), how organizations employ colorblind processes (implicit or explicit) to perpetuate racial inequality in organizational spaces (process), and how

racial categories and perceived racialized expertise have varying levels of influence on organizational behavior (logic). To achieve this, I rely on in-depth interviews with Black executive DEI and health equity professionals to help elucidate these findings by describing their experiences in healthcare settings.

In this chapter, I illustrate:

1. ***Race as Strategy:*** How organizations leverage Black executive leaders and their perceived racial expertise to conform to societal expectations and bolster legitimacy. They react to societal demands to prioritize equity and DEI, using Black leaders as a performative means to demonstrate organizational progress
2. ***Race as Process:*** How organizations demonstrate a public commitment to racial equity, which is contradicted by actual organizational practices and norms (e.g., racism, censorship at work)
3. ***Race as Logics:*** How the adherence to racial hierarchy (white supremacy) to organize work, based on assumptions about racial and ethnic knowledge an employee possesses, creates a scenario where Black executive leaders feel tokenized and hired solely because of their race

This work acknowledges the distinctions between DEI and Health Equity positions while emphasizing the importance of both due to their simultaneous emergence, relative misunderstanding in the healthcare setting, and shared challenges related to organizational change and prioritization of historically underrepresented populations. The argument presented is that without a race-conscious analytical framework, hospitals, which often adhere to corporate business models with race-neutral organizational structures and processes, hinder the ability of Chief Health Equity and DEI officers to enact significant organizational changes in their roles.

For organizations genuinely committed to advancing DEI and health equity efforts, there needs to be an acknowledgment that race is ever-present and functions as a form of status that can be accepted, institutionalized, or rejected (Wooten, 2019). Challenging the status quo regarding race in organizations

necessitates an explicit recognition of how race permeates the daily life of organizations (Ford, 2010) and a willingness to mobilize in support of the work of Black executive leaders in DEI and health equity-focused roles, ultimately benefiting the organization as a whole.

4.3 Study Design and Methodology

To address my research questions, I conducted semi-structured interviews to explore the influence of organizational characteristics, such as reporting structure, budget allocation, and corporate censorship, on the leadership experiences of hospital equity and diversity officers. Qualitative research methodology was chosen for its suitability in capturing the voices of participants and intentionally centering minoritized and marginalized "research subjects" (Busetto, Wick, Gumbinger, 2020).Qualitative methodology makes sense for capturing voices because it allows for a deep dive into individual experiences and perspectives. Unlike quantitative methods, which may gloss over nuances, qualitative approaches provide a platform for participants to express themselves fully. Through open-ended questions and probing dialogue, I could extract rich narratives that illuminated the intricate dynamics of leadership within healthcare organizations.

Additionally, qualitative research fills the gap of quantitative data by offering a holistic understanding of phenomena. While quantitative methods excel in providing numerical trends, they often overlook the human element—the stories, emotions, and complexities behind the numbers. In my study, I aimed to amplify the voices of those whose perspectives are often marginalized within dominant discourses. This study was determined to be exempt by the University of Michigan Institutional Review Board.

Sampling Frame & Recruitment

Since there is no comprehensive list of hospital equity officers available (Weissman et al., 2023), I used a convenience sample to create the data set. I worked with a health equity and DEI leadership group, convened by a non-profit organization dedicated to promoting evidence-based best practices in

organizational leadership. First, an administrative professional agreed to send an email to all members (n = 60 members) describing my interest in interviewing chief health equity and diversity officers. The email specified that I was looking to speak with members who held the most senior position responsible for health equity or DEI in their organizations and met two criteria: they identified as Black/African American, and they had held the equity or DEI officer position for at least one full year.

It is important to note that information about the Chief Health Equity Officer role, their scope of work, and how they prioritize health equity initiates is limited (Weissman et al., 2022). In this study, Chief Health Equity Officers were identified as individuals collaborating with the broader healthcare system to advance health equity and enhance support for underserved communities. They are engaged in establishing measures of equity within hospitals/health systems and coordinating efforts to improve health equity organization wide. DEI officers are largely defined as individuals leading initiatives to create inclusive healthcare environments where everyone feels welcomed, valued, and safe (Goldstein, Grewal, Imose, and Williams, 2022). These officers implement training sessions, establish business resource groups, create scholarship programs, and enhance hiring practices. Their focus is on uplifting diverse populations and contributing to improved health equity both within their organizations and in the broader community. Additionally, the study was open to engaging with senior-level individuals holding positions that blend both DEI and health equity responsibilities.

Through this recruitment process, I obtained 11 interested participants. Ten (10) individuals met the inclusion criteria, and one expressed interest but did not meet the inclusion criteria. This participant kindly referred me to some of their colleagues. After the initial interviews, I used a snowball sampling technique, asking research participants to refer me to other senior-level or executive colleagues responsible for DEI or health equity at different hospitals or health systems (Babbie, 2011). Though this method has its limitations, particularly in that it creates a sample of individuals who may share similar characteristics and traits, the use of a snowball sample nonetheless allowed me to reach a broad range of Black executives across the country. The snowball sampling technique expanded the interviews by 7 additional participants, resulting in a total of 17 interviews conducted via Zoom.

Table 1: Description of Interviewee Positions and Represented Healthcare Organizations

	Title of interviewee	**Total Revenue (Billions/*Millions USD)**	**Teaching**	**Beds**	**Health System**	**Both DEI and Health Equity Responsibilities**
1	Senior Vice President Diversity, Equity, and Inclusion	7,700	Y	609	Y	N
2	Chief Diversity, Equity, and Inclusion Officer	4,600	Y	1,491	Y	N
3	Chief Health Equity Officer	1,429	Y	484	Y	N
4	Chief Community, Health Equity, and Social Impact Officer	3,987	Y	877	Y	Y
5	Chief Health Equity and Inclusion Officer	5,900	Y	1,107	Y	Y
6	Chief Minority Health Services Officer	*257,101	N	161	Y	Y
7	Chief Diversity, Equity, and Inclusion Officer	6,922	Y	520	Y	N
8	Chief Health Equity, Inclusion and	*506,100	Y	200	Y	Y

	Belonging Officer					
9	Chief Diversity, Inclusion, and Talent Management Officer	28,000	Y	8,700	Y	Y
10	System Assistant Vice President for Health Equity	7,100	Y	312	Y	N
11	Chief Equity and Inclusion Officer	1,400	N	1,812	N	Y
12	Chief Inclusion Officer	4,745	Y	628	N	N
13	Chief Inclusion, Equity, and Diversity Officer	11,200	Y	5,000	Y	N
	Chief Health Equity and Inclusion Officer	21,600	Y	537	Y	Y
14	Vice President, Health Equity	5,400	N	938	Y	N
15	Vice President, Health Equity	11,200	N	5,000	Y	N
16	Chief Health Equity Officer	28,000	N	697	Y	N
17	Chief Diversity, Equity, and Inclusion Officer	3,309	Y	1,000	Y	N

Design

An original semi-structured interview guide was developed and used for all interviews. The interview guide was informed by the sociological framework, theory of racialized organizations (see Chapter 1), and focused on understanding how organizational characteristics impact the leadership experiences of chief leaders (e.g., budgetary and staff support, censorship, reporting structure, performativity) (see Figure 1). The interview guide was piloted with one Chief Health Equity and Inclusion Officer at an academic medical center. This preliminary interview informed scoping of the interview content. It also helped ensure the language used in the interview guide was widely accessible for potential interviewees. Interviews were conducted from June 2023 to September 2023 and lasted approximately 60 to 90 minutes.

Positionality and Interviewing

As an African American woman, I anticipated that our shared racial status, and in some instances, shared racial and gender identity, would foster openness between myself and respondents. While some argue that shared racial status does not necessarily facilitate rapport (Gallagher, 2000), in this study, participants may have felt a level of comfort discussing their experiences with race and organizational norms, assuming that I could sympathize and identify with their experiences. The study's sample lacks interviews with respondents of other races, preventing a direct comparison between Black executive leaders and their counterparts of different racial backgrounds.

The focus of interview questions centered on understanding how Black executives navigate their roles as Chief DEI and health equity officers within a racialized healthcare organization (see Appendix for Interview Guide). Participants provided insights into their professional journey leading up to their current position, outlined the responsibilities of their current role, and described the racial climate within their organization. Discussions extended to the diversity within hospital leadership, examining whether it reflected the broader employee workforce and communities they serve. The emotional dynamics within these discussions were diverse; certain participants voiced their desire for me to document their dissatisfaction in the role, while others expressed a general satisfaction with their roles but shared the

labor involved in having to codeswitch within predominantly white spaces. Additionally, participants shared perspectives on how success is measured in their role and for broader DEI/health equity initiatives, organizational support received (including staff and budget), and any internal or external barriers influencing their job functions.

Analysis

The analysis for this study employed a narrative approach consistent with the qualitative methodology outlined by Feldman, Skoldberg, Brown, & Horner (2004), which prioritizes the interpretation of participants' stories and experiences. To ensure a comprehensive understanding of the data, interviews were transcribed professionally and subsequently coded using MAXQDA software.

Coding Process

The coding process began with the development of a preliminary coding scheme based on the interview questions. This initial framework guided the subsequent analysis. During the preliminary phase, I reviewed a small subset of transcripts in Microsoft Word, annotating potential codes, themes, and necessary adjustments to the coding structure. These annotations informed the refinement of the codebook. The coding and re-evaluation phase involved the systematic application of codes to all transcripts using MAXQDA. As the sole coder, I analyzed the data, identifying areas within the codebook that required attention. This iterative process included revising codes, providing clarifications where needed, and incorporating any missing codes. The final version of the codebook, included in Appendix C, encapsulates the nuances of the data and reflects the emergent themes.

Thematic Grouping

Thematic grouping was integral to the analytical process. I categorized the coded data into thematic clusters to facilitate interpretation (see Figure 2). These clusters were guided by the fundamental role of race within organizational contexts and were organized into the following categories:

- **Race as Strategy:** This category encompasses codes related to the strategic initiatives and approaches organizations employ to address racial diversity, equity, and inclusion. Codes such as

Role Creation (Chief DEI/Chief Health Equity/or Dual Role), Budget, Staffing, and Organizational Strategic Vision and Mission contribute to understanding how race is strategically integrated into organizational frameworks.

- **Race as Process:** Codes within this category illuminate the ongoing processes and dynamics related to race and racism within organizations. Themes such as Hiring, Career Advancement, and Racialized Labor highlight the systemic challenges and opportunities inherent in organizational structures.
- **Race as Logics:** This category delves into the underlying logics and ideologies that shape perceptions and actions related to race and racism within organizations. Codes such as Performativity and Censorship shed light on the discursive and performative dimensions of race discourse within organizational contexts.

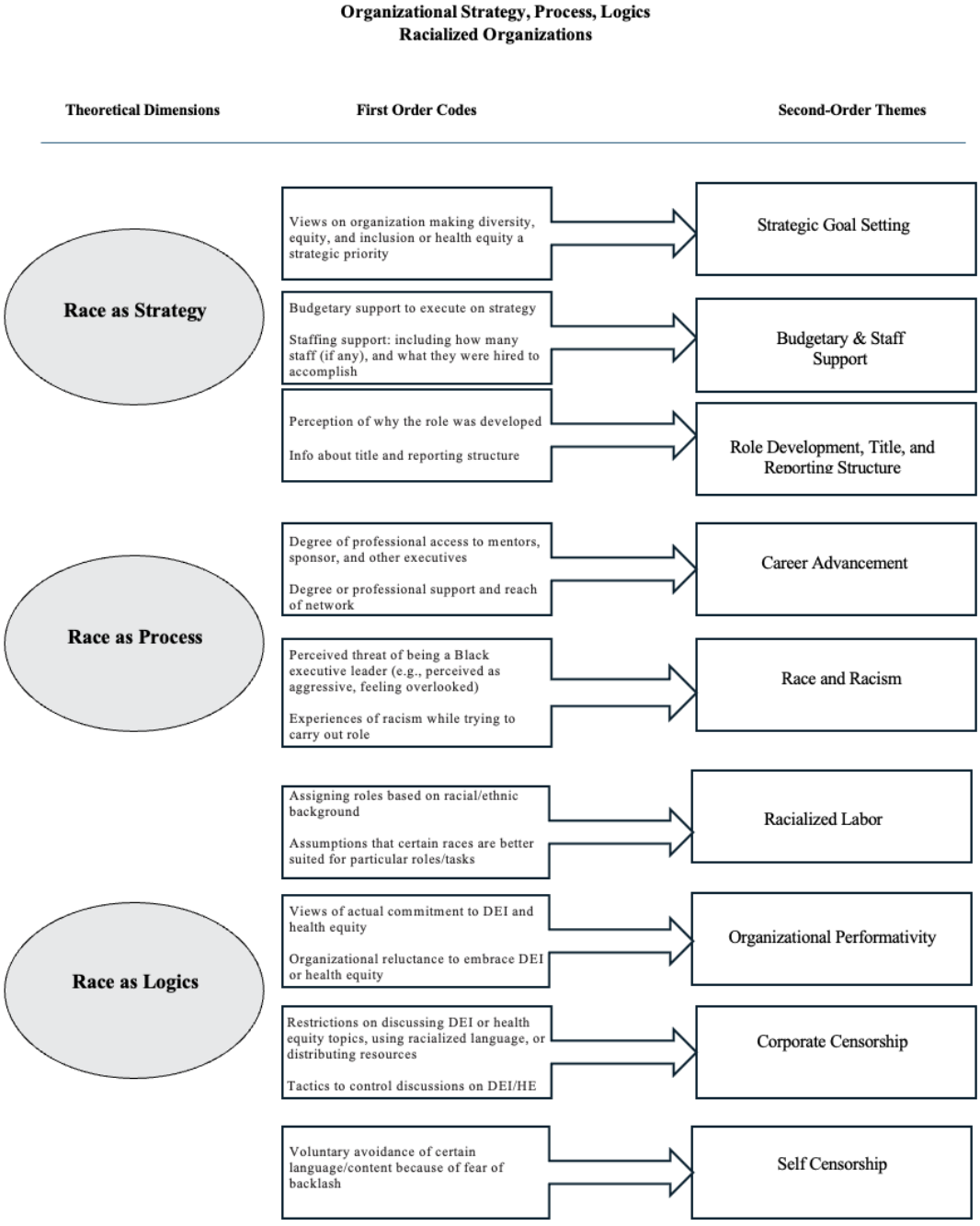
Figure 3 Graphic Illustration of Theory of Racialized Organizations Literature and Paper Themes



Note: This graphic was developed based on the readings provided in Wooten, M. (2019). *Race, Organizations, and the Organizing Process*. Emerald Publishing Limited.

Throughout the analysis, I documented major themes emerging from the data. An initial results document was created to capture these themes, supported by relevant quotes from the transcripts. As the analysis progressed, the results document underwent continual refinement, with quotes potentially being relocated to appendices or removed altogether to ensure clarity and coherence in the presentation of findings.

Figure 4 Organizational Strategy, Process, Logics Racialized Organizations



4.4 Results

A total of 17 Black executive hospital leaders participated in this study seeking to understand how Black executives advance health equity and diversity, equity, and inclusion efforts within racialized organizations. Among the executive leaders I interviewed, there were three distinct roles: Chief Diversity, Equity, and Inclusion (DEI) officers (CDOs), Chief Health Equity Officers (CHEOs), and individuals occupying positions with a combined focus on DEI and Health Equity responsibilities.

Distribution and Type of Leadership Roles

The breakdown of leadership roles is as follows: 6 individuals held the title of Chief Health Equity Officers (CHEOs), 5 individuals served as DEI Officers (CDOs), and 6 individuals assumed roles that blended both DEI and Health Equity responsibilities (see Table 1). Individuals occupying the CDO role demonstrated a primary focus on developing a welcome work environment for people of all genders, races, cultures, ages, and abilities within their respective organizations but also ensured that a DEI lens was integrated into patient-facing initiatives. Their key responsibilities involved implementing strategies to create a more diverse workforce, promoting an inclusive organizational culture, workforce training and development, and addressing disparities related to race, gender, and other dimensions of diversity (e.g., accessibility, age, sexual orientation).

CHEOs, in contrast, dedicated their efforts specifically to advancing health equity initiatives. Their primary responsibilities revolved around the development and execution of strategies geared towards mitigating health disparities, ensuring equitable access to healthcare services, embedding health equity principles within the health systems, and addressing social determinants of health (e.g., food security, housing, transportation) that influence the health of people and communities.

Individuals occupying mixed roles described having responsibilities related to both DEI and health equity, generally describing themselves as responsible for the development and implementation of leading diversity initiatives that differentiate their health system, and also developing strategies that address racial disparities in healthcare.

Race as Strategy: Perceptions of Role Creation, Titles, and Organizational Support

This category is categorized under "race as strategy" because it details how organizations strategically hired Black executive leaders to meet societal expectations and showcase organizational progress. Numerous executive leaders provided insights into the rationale behind the creation of their roles and offered perspectives on the appropriateness of their organizational reporting structure and titles. The majority of interviewees were pioneers in their respective roles, with an average tenure of 2 to 4 years. Many expressed the challenges associated with prioritizing DEI and health equity within health systems, highlighting significant uncertainty surrounding strategic planning and execution in these areas.

> "This is so incredibly new in terms of a focus in healthcare, more broadly, that there's not really a template to follow, and a lot of stuff that you're doing, you're creating. So there wasn't necessarily a health equity or DEI scorecard that we could just say, "This is what they're doing, let's just see how we can adapt it to our environment."

Some acknowledged that although there is uncertainty around strategic direction, several interviewees noted that they felt that their academic training, as a doctoral-trained sociologist for example, allowed for them to adapt quickly into their new role:

> "As a doctoral trained sociologist, I do understand how organizations work and institutions work. And so, if you understand how organizations and institutions are structured and how they function, you're just really moving from one context to another, even when a field is emergent within an industry. So, really, the only learning curve was really understanding the culture and the context of that particular institution, not learning institutions more broadly. And so I really spent a lot of time focusing on that, like, this is the skillset that comes from being a sociologist. This is how the skillset can be used for your benefit as an equity-focused executive leader."

Many indicated that the social unrest in 2020 influenced the establishment of their positions. Interviewees stated:

> "*I am the first to hold this position and I started from zero with no budget or staff support.* I believe Affirmative Action serves as the tipping point for what's unfolding. In 2020, the murder of George Floyd placed immense social pressure on organizations to prioritize these issues. As I mentioned earlier, *when pressure and change stem from grassroots movements, organizations tend to adapt more swiftly*. It became an expectation for organizations to address these issues and demonstrate tangible commitments. There was a burst in job openings and new positions in the DEI field during the 2020 timeframe and the subsequent year. While I informally tracked this

> trend on LinkedIn, I observed a significant increase in DEI-related job postings. As we emerged from the pandemic and began to transition, I believe that Donald Trump's presidency also played a role in heightening awareness and attention to both DEI and health equity. It prompted individuals to recognize the harm experienced by marginalized communities, both within and outside of the workplace."

> "Everybody's on this high because George Floyd was murdered in front of everyone's eyes. So now, these organizations feel like they need to establish these executive roles, but whose idea is this? And who am I reporting to? There was a few places I interviewed where I reported it to HR, but I knew from my work at my previous organization that I needed to have a seat at the leadership table, report to the CEO and a budget, full stop. Without that, it becomes very difficult to get anything done. Or, you will spend a lot of time advocating for your team to get the resources you need"

Some executives, however, had a different experience. They shared that having an existing infrastructure in place was useful for implementing recommendations effectively. One executive emphasized the benefits of inheriting a strategic framework rather than starting from scratch:

> "I was attracted to this organization because this wasn't a fresh build and there was a foundation that was already in place. I didn't want to build. I didn't want to start 101. I wanted to inherit something that was more sophisticated. I didn't want to have entry-level conversations around this is why we do this work and this is why it's important. Someone else already set that foundation, which I've benefited from. I'm grateful for it. So that was not the case, but also it allowed me to apply a different level of strategic thinking to the organization."

Titles and Organizational Support

Some expressed satisfaction with their titles and reporting relationships, noting alignment with their responsibilities and the organization's commitment to diversity, equity, and inclusion (DEI) and health equity initiatives. These leaders often emphasized the significance of having titles that accurately reflected their roles and acknowledged the importance of clear reporting lines to facilitate effective leadership and decision-making processes. For example, one participant stated:

> "My title is reflective of the work I do. *I report to the CEO and oversee five teams*. I have a vice president who reports to me and oversees the day-to-day operations for diversity, learning, talent, community, and health equity innovation. They serve as the primary leaders for their respective areas and manage their own teams. I have a direct report for each of these five teams, responsible for leading the work, making hiring and firing decisions, and crafting strategies. This forms the core structure for each team. Additionally, there's an operations hub within my team, where I have a chief of staff who collaborates closely with each of the five leaders. She effectively supports their operational needs, including budget management, call center operations, and goal advancement, aligning with my vision on a daily basis to ensure progress. Moreover, I oversee an

> executive assistant who coordinates my schedule and ensures I am where I need to be when required. This team comprises my assistant, chief of staff, and the five leaders overseeing operations for each team. *The direct reporting line to the CEO empowers me to drive impactful change and the allocation of sufficient budgetary resources enables them to execute their initiatives effectively*."

However, that leader's experience was an outlier. The overwhelming majority of leaders expressed discontentment with their titles and reporting structures within the organizational hierarchy. They shared concerns about titles that may not capture the breadth and depth of their responsibilities in advancing DEI and health equity objectives. For example, one leader stated:

> "*I don't feel my title is sufficient.* If diversity and health equity is meant to be foundational everywhere, *my title is buried within the system*. If you were to look at the org chart externally and objectively, it seems as though diversity, in particular, isn't truly valued, despite our statements as an academic medical center. We claim diversity, equity, and inclusion as high values, yet *my title, the highest dedicated to this work, is four or five rungs down in the system.* I believe my title should be changed to Chief Diversity Officer and Senior Vice President for Health Equity in the hospital, or maybe Senior Vice Dean for Health Equity and Inclusion. My role encompasses a lot of work and engagement with many people. So, if we truly value diversity and inclusion and health equity, we need to acknowledge it accordingly."

Another leader stated that their organization hired an external consulting firm to assist them with their reporting structure, and even though the firm recommended that the Chief Health Equity Officer role be position in the C-suite, the organization ignore the recommendation:

> "I should report to the CEO. The executive leadership team actually hired some consultants to follow us for about two years, and one of their final recommendation was to change my job classification and add me to the C-suite. They completely ignored the recommendation. So who knows, maybe it'll happen at some point, but for now, I am not even EVP level, but I get to say I am the chief. Sometimes I do think the consultants recommendations were ignored because I am the first Black woman to hold this position and this org isn't ready for a Black person to join the executive team."

Moreover, within the context of racialized organizations, challenges arose from unclear reporting structures and limited authority. Several participants noticed that this hindered their ability to enact meaningful change and strategic initiatives. As voiced by one participant:

> "*They are paying me at a manager level and the reporting structure is all wrong*. They gave me one or two staff to support the work. An embarrassing budget. But the organizations want the credit of having a *token Black Executive* in the seat, but you're not creating the budget, the

> staffing resources, the compensation at that level. So there's really been, from my perspective, again, a bastardization of this role, for lack of a better term. We've skinnied down what the role means. Nowhere will you find a Chief Financial Officer who's also operating at a manager level. Nowhere will you find a general counsel or a head lawyer who's operating as a manager. *It's unfortunate and traumatizing, this reporting and resource issue may be because many people of color take this position on. I am a Black person trying to do this work in a hostile environment.* I think to some extent we're still wrestling with what is the role and responsibility of a Chief Diversity or Health Equity Officer even is"

And several offered insights into the synergies between DEI offices and health equity offices. Often, these offices operate separately. During an interview, one executive, who is part of one of the few offices where DEI and Health Equity are combined, shared their thoughts on the organizational structure:

> "*We're one of maybe five or seven in the country that are together.* I think there's opportunities for more hospitals to put DEI and Health Equity together. It does take strong leadership, even within the office, at multiple levels. And so I would advocate for having another dean in our office and another vice president, associate vice president in our office under me because that would give them the gravitas to do the work. Even though it's a large amount of work, the reason why I think it's okay to be together because they're so interrelated. *In order to have health equity, you need to know about diversity and inclusion. You need to know about belonging, you need to know about equity, including health equity and job equity. All of those things are related. We really should not be separated, and if we are, we need to make sure there is alignment. No silos. We must talk to each other, so we can join forces. There is no time to reinvent the wheel, it is a waste of time*."

Race as Logics: Race and Racism & Career Advancement

This emergent theme, race and racism, aligns with the theoretical concept of "race as logics"," as it explores the underlying racialized assumptions and beliefs that contribute to the creation of scenarios where Black executive leaders feel tokenized and hired solely because of their race. Interviewees provided detailed insights into how being a Black person in an executive leadership role influenced their ability to gain organizational buy-in to advance DEI or health equity efforts, while also navigating instances of racism and censorship. They discussed an enhanced awareness of their racial/ethnicity identity, and in some cases, the intersectionality of race and gender, when operating within predominantly white healthcare organizations and leadership teams. Every interviewee confirmed that they experienced racism at some point in time during their tenure as an executive.

Race and Racism

One interviewee shared the psychological toll being a Black male on a predominately white leadership team has on him:

> *"For me, every day I have to realize the seat in which I sit, but I also have to be mindful of what's oftentimes the unspoken, I'm Black and I am a man.* So what does that mean when I raise my voice in a meeting? Healthcare, as you know, the overwhelming majority of healthcare are women, particularly white women. *So if I'm in a meeting and I'm raising my voice. They will say in public settings that I'm insisting and demanding.* I can never just say "You need to do this. You need to do it this way," I got to be mindful of that perception. *I have to be mindful of my interactions and how people perceive me if I want to get any sort of work done around here. A white executive leader who is doing dei or health equity work, just would not have to deal with this on top of their job responsibilities. Racism complicates my role and how my organization understands it, what i'm able to do as a leader, and the impact the work can have at the end of the day and patients suffer because of it"*

Others shared their feelings about how they are treated by their leadership teams and how they navigate working within racialized organizations:

> "*They just hate me because my skin is Brown.* And how do I know that? Because some of the same people who I sat in the room with at the meeting 30 minutes ago, when I see them walking they don't look my way. Now, they may be thinking about their patients or what they're going to serve for dinner or where they're going on vacation. I don't know what they're thinking about, but you can't look at me? And you know my name. Are you kidding me? It makes me feel invisible"

> "One, you need to know all of the ins and outs. It takes a couple years just to understand the system, how things work, who are your allies, who are not, who are all the people. And then it takes even longer, if you're a person of color or a woman or from any minoritized background, to feel comfortable speaking up, how to present, how to manage your imposter syndrome and also manage the biases that happen in organizations designed to prioritize whiteness first. Even though I'm in this role and I have this title, it's common that I'm in a leadership meeting and I'll say something, and it won't be until someone else repeats it that it'll get accepted. Being an executive does not protect you from racism, it happens at the executive level. And if you're a person of color, you could get very frustrated with this quickly and want to leave."

Even on diverse leadership teams, participants recognized that executives who identify as Black or people of color are often the most harmed and susceptible to racism in predominantly white organizations. One participant stated:

> "No matter the makeup of the team, when you are Black, the white people tend to not realize that there's a lot of trauma and stuff that comes from working for an organization not designed for you."

Another executive leader shared:

> "Our team is probably the most diverse team that exists in the organization, which, in some ways, makes a lot of sense and might be what you expect, but also goes back to *the people who are often the most harmed in the predominately white organizations are also the people doing the work to try to make the organizations feel safer*. Our team is generally a safe space, but the Black executive leaders, in particular, experience racism too often to count at work, and it adds another layer of complexity, being Black, to an already difficult role"

Career Advancement

Interviewees provided insights into how they actively pursue professional development opportunities while in their roles. One interviewee stated that while she has a lot of DEI-specific knowledge, she has never worked in healthcare. For her, it was important to hone her healthcare knowledge to better perform in her role, she states:

> "I still have a lot to learn about healthcare. So I even was considering the MHA because there's really so much for me to learn about the systems that make medicine run, reimbursements, insurance, how RSUs work, how we assign work, operations and supply chain. I'm a very experiential learner... A lot of my learning comes through my opportunities to interact with executives who are doing this work and talk to them about what they're doing and how they're structuring the work."

While another interviewee shared that she has committed herself to getting rid of board membership commitments where she is the only expert, because she is spending a disproportionate amount of time explaining to people how to do health equity and DEI work. Instead, she prefers to spend her professional development opportunities learning from others who have been in this field for a longer period of time:

> "So when I started this role, I realized I needed some professional development. And so, I took a year to look around at programs and I found the Culture of Health leadership program at Robert Wood Johnson. And I did that because I did feel I needed some growth in this space. And so, that was a three-year program. I was around people who were doing all kinds of amazing things across the country…. My strategy now is... And I started executing this strategy in January, to get rid of boards where I was the expert, because that was a waste of my time. I don't really want to spend time explaining to you how to do this. So now, I'm on two boards where I'm sitting at the table with other people who've been in this space for a long time."

Race as Process: Performativity, Censorship, Racialized Labor

This category falls under "race as process" because it delves into how organizations showcase a public commitment to racial equity, only to have their actual practices and norms reveal a different story (e.g., instances of racism, workplace censorship). Through the voices of numerous executive leaders, I

gain insights into their perceptions of whether their organizations' endeavors towards advancing DEI and health equity are genuine or performative. They shared instances where they felt compelled to self-censor because they sensed their organization wasn't prepared to confront certain ideas, as well as cases where individuals were actively censored by the organization.

Performativity

During discussions about racism, I asked whether interviewees believed their organizational efforts towards advancing health equity and DEI were performative. Responses varied, with some leaders expressing optimism that policy shifts would solidify health equity initiatives while acknowledging the precarious nature of DEI efforts:

> "I feel like it's not entirely performative . There's still some performativity, but I believe it will eventually become embedded in how we do work because organizations won't have a choice due to the health equity accreditation standards. When organizations and institutions fail to enact change themselves, policies force them to do something. Accreditation is one policy that is driving organizational transformation in Illinois, which I believe will have a positive impact. On the other hand, there will always be individuals resistant to change. Some fundamentally misunderstand or disagree because it's not reflective of their lived experience. DEI efforts remain at risk, and we're already witnessing DEI initiatives being dismantled across the country."

Others held strong opinions regarding organization's performativity, urging them to reassess their readiness to support a Black executive leader and support them in their efforts to advance DEI and Health Equity work:

> "I challenge these organizations that create these Chief DEI and health roles. Are you truly trying to make change? Or do you just want to be on the bandwagon to say you have someone since we were pushed to create these roles in our field? *You would never go to a specialist in medicine who was not clearly academically trained to do that work. So why do organizations think that just anybody, by virtue of being Black or of color in some way, shape or form, can just do this work with no support or leadership engagement? I don't know why they think that racial identity, alone, is the measure.* And that's always been an issue for me. Nobody really looks at actual training and expertise in this space. They just want someone who they think can pass. *And that diminishes the role and it diminishes the authority of it, which is why a lot of these are just not working."*

Self & Corporate Censorship

Self censorship and corporate censorship falls under "race as a process" as it addresses specific organizational practices (censorship) that contradict the organizational commitment to racial equity, highlighting the discrepancies between organizational rhetoric and actual practices. Many executive leaders discussed the practice of self-censorship, revealing that they often refrain from using terms such as racism or other -isms in strategy documents and materials intended for external consumption. This self-censorship arises from an understanding that such language might not be well-received by the leadership team or could potentially generate resistance within the organization's culture of dialogue and change. However, a few interviewees felt empowered by their executive leadership team and expressed that they could be honest about the state of racism and healthcare in this country. For example, one participant said their CEO often says:

> "You can't be innovative if you're not in a place where the people who make the decisions and pay the bills are willing to be disturbed and be made uncomfortable by the fact that you're doing something differently. That means telling the truth about where we are as a country. As a society. And that's one of our CEO's mantras. He likes to say that we need to be disrupting ourselves, and it's an overused word, but in this scenario, I think it's valid."

Executive leaders also talked about the challenges of corporate censorship. They highlighted instances where they felt constrained in openly discussing issues related to racism and equity in board meetings or other organizational gatherings. Often, they described restrictions in publishing external documents that openly address progress and commitments toward racial equity, fearing the public eye will hold them accountable. This corporate censorship significantly impedes the ability of executive leaders to drive meaningful change and transparency in advancing equity within their organizations. One leader gave an example that clearly shows the challenge of navigating racialized organizations while advocating for discussions on structural racism:

> "So I know how to code switch really, really well. And I use language and concepts depending on the audience. That is because I am not really empowered to say the word racism. But, we have to talk about structural racism. Who hires a Chief DEI or Health Equity Officer and tells them they can't say the word racism? It is unthinkable but happens more than we'd like to admit. Now, where I live and work is straight up red. The whole senior leadership voted for Trump, straight up red. So this is the context in which I said, "We have to talk about structural racism." I remember going before the board, my heart was thumping, and I said, "We have to talk about this if we're really going to improve the health of our communities." I used the term structural racism

> against my organization's cultural norm, but I presented very benign. I'm not a threat, I cannot be viewed as a threat in leadership meetings. I had a smile and I dressed a certain way and everything. Long story short, I took a CEO who has struggled to say the word racism, deleted the word racism for our organizational documents in the past, possibly buying into the work, but it was a stressful day."

The narrative shared by this participant, challenging organizational norms and advocating for the public acknowledgment of terms like "racism" and other -isms, resonated with many others in similar positions. For numerous Black executive leaders, cultivating an image of approachability, warmth, and affability became a strategic approach to navigate racialized organizations and predominantly white executive leadership teams. This image served multiple purposes: 1) ensuring job security, 2) garnering organizational buy-in, and 3) addressing apprehensions and resistance towards acknowledging the role of racism in healthcare.

4.5 Discussion

My research delved deeply into the experiences of Black executive leadership within racialized health systems, exploring the implications for their strategic vision and the challenges they face in navigating organizations that exploit race for strategic purposes, whether implicitly or explicitly. It unpacked how racial dynamics are ingrained in organizational policies and structures, placing a disproportionate burden on Black executive leaders in Diversity, Equity, and Inclusion (DEI) and Health equity to create strategic goals for their organization, often with insufficient budget or staff support. Additionally, it highlighted how colorblind policies and procedures persist, often censoring Black leaders from publicly acknowledging the role racism has played in their organizational history, healthcare overall, and in their ability to be successful in their role.

Drawing from the collective experiences of participants and existing literature, my study provides tangible illustrations of the realities faced by Black executive leaders in healthcare settings, where many institutions fail to confront their history of prioritizing whiteness as the norm. The interviews with executive leaders revealed pervasive feelings of discontent, stress, and disillusionment due to the lack of organizational support and meaningful engagement with DEI and health equity initiatives. These findings

align with recent acknowledgments from equity officers, recognizing the pervasive influence of white supremacy and its cultural norms within healthcare systems (Weissman, 2023).

This research marks one of the initial attempts to grasp the challenges and opportunities facing Black executive leaders in roles centered on DEI, Health Equity, or both. It connects their leadership experiences with the racialized organizations literature to explain why we continue to see high turnover, and, frankly, the confusion surrounding the expectations and objectives of holding such positions. I aim to shift the focus from individual to organizational failure, highlighting organizations' reluctance to adopt a race-conscious framework and allocate sufficient resources for these leaders to succeed. Previous literature often examined diversity and equity roles separately. This study emphasizes their interconnectedness and suggests that organizations begin to critically consider the need to break down silos and encourage collaboration to achieve meaningful progress in health equity and diversity, equity, and inclusion efforts.

Theoretical Contributions and Avenues for Future Research

I make two primary contributions to the literature on racialized organizations. First, I advance the conceptualization of race as strategy, process, and logic, particularly in relation to the success of Black employees in DEI and Health Equity-focused executive leadership positions. While existing research often highlights specific strategic processes within organizations—such as the racialized burden of Black employees to announce commitments to diversity, equity, and inclusion during protests for George Floyd’s family to receive justice, or the reliance on Black healthcare professionals like doctors or nurses for "equity work" (Wingfield, 2019) —none has examined how these racialized dynamics detrimentally affect Black executive leaders hired to advance health equity and DEI initiatives. Despite holding high-powered and influential positions, Black executive leaders often face barriers due to racialized organizational norms that censor their voices, stall the progress of their strategic vision, and limit their career advancement.

My work expands on existing research by honing in on the executive leadership level, shedding light on how race fundamentally shapes organizational dynamics. It underscores that even with high-

powered titles, Black executive leaders are not immune to the impacts of race within organizations. My findings demonstrate that leaders frequently encounter obstacles such as lack of budget, staffing, or support from executive leadership—which directly hinder their ability to actually accomplish the work they were hired to do. I argue that this is not by coincidence. Despite their esteemed titles, the prevailing racialization within healthcare systems diminishes the perceived significance of their roles compared to more "traditional" executive titles like Chief Financial Officer or Chief Human Resources Officer. These findings align with recent research exploring the experiences of equity officers in United States hospitals (Weissman, 2023) and broader literature documenting increased racism, lack of career advancement, and leadership support for Black executive leaders (Collins, 1989; Brinson, 2006; Anderson, 2011; Holder, Jackson, & Ponterotto, 2015; Roche & Passmore, 2023). However, my research does allow us to contend with the way these processes manifest themselves in executive leadership teams. It pushes us, as a field, to think about how race matters in work and executive leadership, what it means to be a Black executive leader in a newly designed role, and despite the slow change in racial dynamics in organizations, race remains a fundamental element in organizations and inform the success or failure of Black leaders in DEI or HE-focused executive roles.

Second, my research contributes to the organizational and leadership literature by offering a theoretical explanation for why Black executive leaders in DEI and Health Equity-focused roles often experience “failure” or “burnout”, reframing the discourse to focus on organizational shortcomings rather than individual inadequacies. While there has been discussion about why Black leaders are leaving Chief DEI roles in large numbers, little effort has been made, to my knowledge, to contextualize this trend within the framework of racialized organizations literature or any theoretical construct. This paper offers a theoretically grounded framework for understanding *why* Black executive leaders persistently lack resources, budgetary support, and opportunities for professional development. It sheds light on the troubling reality that Black executive leaders are often silenced by their own organizations, such as being

discouraged from discussing racism, despite its undeniable presence in the history and landscape of healthcare systems.

In examining executive Black leaders, I observe how the centralization of whiteness as the norm prompts Black leaders to engage in self-censorship. They must strategize on two fronts: 1) selling their initiatives to predominantly white leadership teams to garner buy-in and 2) avoiding statements that may discomfort white colleagues and impede progress. Our research reveals that executive Black leaders constantly navigate a delicate balance. On one hand, they aspire to enact meaningful change; on the other, they must manage emotional reactions by their white peers, dispel negative stereotypes, such as being labeled as "aggressive," and discern when to assert themselves or retreat into the background—a phenomenon known as "tempered visibility" (Roberts and Blake-Beard, 2014). Future research should investigate corporate censorship and self-censorship strategies, examining their impact on the advancement of DEI and health equity strategic implementation by executive leaders in the workplace. Additionally, further investigation is needed into the role of trust in Black executive leadership experiences, exploring how organizations compromise employee trust and its effects on morale and organizational outcomes.

Strengths and Limitations of the Research

A strength of my work is that I utilized a qualitative approach to understand the leadership experiences of Black executive leaders who hold DEI and health equity roles, a demographic that have been excluded from current literature. Unlike other studies that have focused on one role type, Chief DEI Officer, or Chief Health Equity Officer, this study considered the leadership experiences of both roles, given the synergies of their roles, and general confusion between the two concepts. I interviewed people across the country who had extensive career experiences and worked for a variety of different health system types, which allowed for rich descriptions and it strengthened the depth of my analysis. There was also racial concordance between the interviewer (me) and the interviewees, which in my opinion, allowed for rich discussion.

However, there are important limitations to consider when interpreting these findings. First, interviews were conducted via videoconferencing, and although participant responses appeared to be candid, it is still possible that participants withheld or modified their responses due to desirability bias or concerns about sharing their responses with their respective institutions. While the intentional focus on interviewing Black executive leaders provided valuable insights into their experiences, the absence of comparison groups, such as non-Black executive leaders in the DEI or health equity space, limits the ability to contextualize Black executive leaders' experiences relative to their counterparts or to identify unique challenges specific to their racial identity. Research has also shown that people with multiple identities can have varied impacts. For example, the majority of the people I interviewed were Black women, and it is possible that interviewees may singularly focus on one identity over another (being Black vs. being a woman), embrace both, alternate between the two, or transcend both identities (Rockquemore & Brunsma, 2002).

Practical Implications

This work serves as a starting point for organizations seeking to better understand the unique challenges encountered by Black leaders engaged in this work. It also provides executive leaders who identify as Black, with valuable insights into the leadership experiences others are having within the organization. Incorporating critical theories, such as the theory of racialized organizations, is essential for organizations to recognize and address the structural biases that perpetuate systems privileging whiteness. For instance, organizations should critically examine the processes and resources required for equity and DEI officers to establish and operationalize their offices and strategic plans, including budgetary allocations and staffing support. Offices that are more traditional to hospitals, such as information technology or clinical departments, often receive pre-existing budgets and staffing allocations, whereas equity and DEI offices may need to fight for funding and staffing support. The same level of respect and organizational backing needs to be provided to equity and DEI offices to ensure their effectiveness in driving transformative change. Organizations must acknowledge that equity and DEI efforts require

substantial investment and support to address systemic barriers and promote inclusivity. By recognizing the importance of equitable resource allocation and leadership support, organizations can create environments where Black executive leaders and their counterparts can thrive in advancing equity and inclusion agendas.

To illustrate, hospitals and healthcare organizations may consider conducting an audit of several organizational norms, policies, and procedures that may impact Chief Health Equity and Diversity Officers, particularly those who identify as Black. Hospitals, health systems, and other healthcare organizations should consider:

- **Managing Expectations:** Reviewing the tasks and responsibilities assigned to executive officers within the first 30/60/90 days to assess the feasibility and realism of the expectations set for new DEI and HE officers.
- **Performance Metrics Alignment:** Ensuring that performance metrics and goals are aligned with the officer's role and responsibilities, taking into account the complexity and systemic nature of diversity, equity, and health equity initiatives. Avoid placing unrealistic or disproportionate expectations on Black officers to single-handedly address systemic issues without adequate support or resources.
- **Fair Compensation & Job Classification:** Reviewing the compensation package and job classification offered to Black executive leaders to ensure it aligns with their skill sets and the demands of the role.
- **Career Sponsorship & Engagement:** Ensuring that career opportunities presented to Black executive leaders align with their career aspirations, and not solely focusing on roles targeted towards serving Black/people of color. This approach prevents the leader from feeling pigeonholed into only one type of role.
- **Succession Planning and Leadership Pipeline:** Implementing robust succession planning and leadership development initiatives to identify and nurture future Black executive leaders within

the organization. Provide opportunities for mentorship, career coaching, and exposure to senior leadership roles to prepare aspiring leaders for increased responsibilities and leadership positions.

While some individuals interviewed reported positive experiences, many attributed this to organizational cultures that acknowledge and address historical racism. Organizations with non-white leadership and a deep understanding of systemic racism were often cited as conducive environments for the effectiveness of equity and DEI efforts. This underscores the importance of leadership buy-in and organizational commitment to dismantling systemic barriers. Moving forward, it is imperative that organizations ground their equity initiatives in critical theories while implementing practical and scalable strategies.

CONCLUSION

The imperative for hospitals and health systems to adopt a race-conscious analytical framework, aimed at dismantling the legacy of racism (Weissman, 2023) and elevating the pivotal role of Chief DEI and Chief Health Equity Officers, cannot be overstated. As emphasized by participants in the Robert Wood Johnson Foundation's Raising the Bar Initiative, healthcare systems must embrace structural action — comprehending how poverty, racism, and nativism inflict harm on specific groups through policies and systems, acknowledging healthcare's complicity in perpetuating these inequities, and instituting transformative changes.

While the positions of Chief Health Equity Officer and Chief Diversity, Equity, and Inclusion Officer are designed to enact this mandate, the reality remains stark: many institutions are entrenched in upholding white standards and ideals. For Black Chief DEI and Health Equity Officers, in particular, navigating these roles continues to pose exceptionally arduous challenges, to the detriment of the organization, the patient populations they serve, and the internal workforce. True progress demands a radical reimagining of organizational norms to acknowledge race as a foundational element in its operations and to initiate the necessary steps toward ensuring Chief DEI and Health Equity Officer

sustainability and advancement.

REFERENCES

A Theory of Racialized Organizations—Victor Ray, 2019. (n.d.). Retrieved February 13, 2024, from https://journals.sagepub.com/doi/10.1177/0003122418822335

Abbasi, J. (2020). Taking a Closer Look at COVID-19, Health Inequities, and Racism. *JAMA*, *324*(5), 427–429. https://doi.org/10.1001/jama.2020.11672

Advancing Diversity, Equity, and Inclusion in Medical Education. (n.d.). AAMC. Retrieved May 13, 2024, from https://www.aamc.org/about-us/equity-diversity-inclusion/advancing-diversity-equity-and-inclusion-medical-education

After Civil Rights | Princeton University Press. (2013, December 1). https://press.princeton.edu/books/hardcover/9780691159966/after-civil-rights

Anderson, E. (2011). The Social Situation Of The Black Executive: Black And White Identities In The Corporate World. In *Covert Racism* (pp. 291–319). Brill. https://brill.com/display/book/9789004207011/Bej.9789004203655.i-461_015.xml

Bachman, E. (n.d.). *The"Glass Ceiling" For Black Corporate Executives Is Really A "Concrete Ceiling."* Forbes. Retrieved November 15, 2023, from https://www.forbes.com/sites/ericbachman/2021/12/16/theglass-ceiling-for-black-corporate-executives-is-really-a-concrete-ceiling/

Bambra, C., Riordan, R., Ford, J., & Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *J Epidemiol Community Health*, *74*(11), 964–968. https://doi.org/10.1136/jech-2020-214401

Barger, A. (n.d.). *Is there a diversity issue among chief diversity officers?* Retrieved December 3, 2023, from https://www.fastcompany.com/90888117/is-there-a-diversity-issue-among-chief-diversity-officers

Bhatt, J., & Maningbe, K. (2023, December 6). *2024 Outlook for Health Equity*. 2024 Outlook for Health Equity Health Equity Leaders May Play an Increasingly Critical Role. https://www2.deloitte.com/us/en/blog/health-care-blog/2023/outlook-for-health-equity.html

Bleser, W., Humphrey, S., Crook, H., Thoumi, A., Cholera, R., Pearson, J., Whitaker, R., & Saunders, R. (n.d.). *Pandemic-Driven Health Policies To Address Social Needs And Health Equity*. Retrieved December 3, 2023, from https://www.healthaffairs.org/do/10.1377/hpb20220210.360906/full/

Bonilla-Silva, E. (1997). Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review*, *62*(3), 465–480. https://doi.org/10.2307/2657316

Bowman, L., Rocco, T. S., Peterson, E., & Adker, W. A. (n.d.). *Utilizing the Lens of Critical Race Theory to Analyze Stories of Race*.

Branch, E. H., & Wooten, M. E. (2012). Suited for Service: Racialized Rationalizations for the Ideal Domestic Servant from the Nineteenth to the Early Twentieth Century. *Social Science History*, *36*(2), 169–189.

Brinson, H. (n.d.). *The effect of race and gender in organizational leadership success: A study of African American women and their challenges to become leaders in corporate America* [Ph.D., Capella University]. Retrieved January 31, 2024, from https://www.proquest.com/docview/304908130/abstract/97BFD4E3833E4F02PQ/1

Brown Suits Need Not Apply: The Intersection of Race, Gender, and Class in Institutional Network Building1—Damaske—2009—Sociological Forum—Wiley Online Library. (n.d.). Retrieved February 13, 2024, from https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1573-7861.2009.01105.x

Brownlee, D. (n.d.). *This Is Why Corporate DEI Tragically Fails Many Black Professionals*. Retrieved December 3, 2023, from https://www.forbes.com/sites/danabrownlee/2022/08/11/this-is-why-corporate-dei-tragically-fails-many-black-professionals/?sh=d0edfe4efbcc

Chief Diversity Officer Demographics and Statistics [2023]: Number Of Chief Diversity Officers In The US. (2021, January 29). https://www.zippia.com/chief-diversity-officer-jobs/demographics/

Clair, M., & Denis, J. S. (2015). Racism, Sociology of. In J. D. Wright (Ed.), *International Encyclopedia of the Social & Behavioral Sciences (Second Edition)* (pp. 857–863). Elsevier. https://doi.org/10.1016/B978-0-08-097086-8.32122-5

Collins, S. M. (1989). The Marginalization of Black Executives*. *Social Problems*, *36*(4), 317–331. https://doi.org/10.2307/800818

Collins, S. M. (1997). *Black Corporate Executives: The Making and Breaking of a Black Middle Class*. Temple University Press.

Corley, T., Pamphile, V. (Voni), & Sawyer, K. (2022, September 23). What Has (and Hasn't) Changed About Being a Chief Diversity Officer. *Harvard Business Review*. https://hbr.org/2022/09/what-has-and-hasnt-changed-about-being-a-chief-diversity-officer

Cornileus, T. H. (2013). "I'm a Black Man and I'm Doing this Job Very Well": How African American Professional Men Negotiate the Impact of Racism on Their Career Development. *Journal of African American Studies*, *17*(4), 444–460. https://doi.org/10.1007/s12111-012-9225-2

Crews, D. C., Collins, C. A., & Cooper, L. A. (2021). Distinguishing Workforce Diversity From Health Equity Efforts in Medicine. *JAMA Health Forum*, *2*(12), e214820. https://doi.org/10.1001/jamahealthforum.2021.4820

Delgado, R., & Stefancic, J. (2001). *Critical Race Theory: An Introduction*. NYU Press. https://www.jstor.org/stable/j.ctt9qg26k

DiMaggio, P. J., & Powell, W. W. (1983). The Iron Cage Revisited: Institutional Isomorphism and Collective Rationality in Organizational Fields. *American Sociological Review*, *48*(2), 147–160. https://doi.org/10.2307/2095101

Discriminative justice: Can discrimination be just? - Rocco—2004—New Directions for Adult and Continuing Education—Wiley Online Library. (n.d.). Retrieved May 13, 2024, from https://onlinelibrary.wiley.com/doi/abs/10.1002/ace.126

Dotson, E., Bonam, C., & Jagers, J. (2017). *Redefining Race as a Process: Implications for Healthcare Leadership*.

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine (1982)*, *71*(8), 1390–1398. https://doi.org/10.1016/j.socscimed.2010.07.030

Goldstein, D., Grewal, M., Imose, R., & Williams, M. (n.d.). *How to set your chief diversity officer up for success | McKinsey*. Retrieved December 3, 2023, from https://www.mckinsey.com/capabilities/people-and-organizational-performance/our-insights/unlocking-the-potential-of-chief-diversity-officers

Gravlee, C. C. (2020). Systemic racism, chronic health inequities, and COVID-19: A syndemic in the making? *American Journal of Human Biology*, *32*(5), e23482. https://doi.org/10.1002/ajhb.23482

Health system chief diversity officers: Who are they and what do they do? - Tory H. Hogan, Lena Stevens, Jennifer L. Hefner, Christy Harris Lemak, 2023. (n.d.). Retrieved December 4, 2023, from https://journals.sagepub.com/doi/10.1177/09514848221115091

HIERARCHIES, JOBS, BODIES:: A Theory of Gendered Organizations—JOAN ACKER, 1990. (n.d.). Retrieved February 13, 2024, from https://journals.sagepub.com/doi/10.1177/089124390004002002

Hoberman, J. (2012). *Black and Blue: The Origins and Consequences of Medical Racism*.

Hogan, T. H., Stevens, L., Hefner, J. L., & Lemak, C. H. (2023). Health system chief diversity officers: Who are they and what do they do? *Health Services Management Research*, *36*(3), 176–181. https://doi.org/10.1177/09514848221115091

Holden, T. M., Simon, M. A., Arnold, D. T., Halloway, V., & Gerardin, J. (2022). Structural racism and COVID-19 response: Higher risk of exposure drives disparate COVID-19 deaths among Black and Hispanic/Latinx residents of Illinois, USA. *BMC Public Health*, *22*(1), 312. https://doi.org/10.1186/s12889-022-12698-9

Holder, A. M. B., Jackson, M. A., & Ponterotto, J. G. (2015). Racial microaggression experiences and coping strategies of Black women in corporate leadership. *Qualitative Psychology*, *2*(2), 164–180. https://doi.org/10.1037/qup0000024

How to set your chief diversity officer up for success | McKinsey. (n.d.). Retrieved May 13, 2024, from https://www.mckinsey.com/capabilities/people-and-organizational-performance/our-insights/unlocking-the-potential-of-chief-diversity-officers

Huang, K., Tapia, A., & Polonskaia, A. (n.d.). *Your Chief Diversity Officer Is Likely Leaving*. Retrieved December 3, 2023, from https://www.kornferry.com/insights/this-week-in-leadership/your-chief-diversity-officer-is-likely-leaving

III, F. C., & Gulati, R. (2021, November 18). What Do Black Executives Really Want? *Harvard Business Review*. https://hbr.org/2021/11/what-do-black-executives-really-want

Increasing and Sustaining Racial Diversity in Healthcare Leadership | American College of Healthcare Executives. (n.d.). Retrieved December 3, 2023, from https://www.ache.org/about-ache/our-story/our-commitments/policy-statements/increasing-and-sustaining-racial-diversity-in-healthcare-management

Jan, T., McGregor, J., & Hoyer, M. (n.d.). *Big business pledged nearly $50 billion for racial justice after George Floyd's death. Where did the money go?* Washington Post. Retrieved November 15, 2023, from https://www.washingtonpost.com/business/interactive/2021/george-floyd-corporate-america-racial-justice/

Johnson-Agbakwu, C. E., Ali, N. S., Oxford, C. M., Wingo, S., Manin, E., & Coonrod, D. V. (2022). Racism, COVID-19, and Health Inequity in the USA: A Call to Action. *Journal of Racial and Ethnic Health Disparities*, *9*(1), 52–58. https://doi.org/10.1007/s40615-020-00928-y

Kawachi, I. (2020). COVID-19 and the 'rediscovery' of health inequities. *International Journal of Epidemiology*, *49*(5), 1415–1418. https://doi.org/10.1093/ije/dyaa159

Kayser, A. (2023, September 12). *Has the fastest growing C-suite role hit a snag? It's complicated*. https://www.beckershospitalreview.com/hospital-management-administration/has-the-fastest-growing-c-suite-role-hit-a-snag-its-complicated.html

Kelley, A. D. (2024). Medical schools as cisgendered organizations. *Social Science & Medicine*, *350*, 116913. https://doi.org/10.1016/j.socscimed.2024.116913

Labor force characteristics by race and ethnicity, 2021: BLS Reports: U.S. Bureau of Labor Statistics. (n.d.). Retrieved December 3, 2023, from https://www.bls.gov/opub/reports/race-and-ethnicity/2021/home.htm

Lee, T. H., Volpp, K. G., Cheung, V. G., & Dzau, V. J. (2021). Diversity and Inclusiveness in Health Care Leadership: Three Key Steps. *Catalyst Non-Issue Content*, *2*(3). https://doi.org/10.1056/CAT.21.0166

Maintaining Hierarchies in Predominantly White Organizations: A Theory of Racial Tasks—Adia Harvey Wingfield, Renée Skeete Alston, 2014. (n.d.). Retrieved February 13, 2024, from https://journals.sagepub.com/doi/10.1177/0002764213503329

McCluney, C. L., Durkee, M. I., Smith, R. E., Robotham, K. J., & Lee, S. S.-L. (2021). To be, or not to be…Black: The effects of racial codeswitching on perceived professionalism in the workplace. *Journal of Experimental Social Psychology*, *97*, 104199. https://doi.org/10.1016/j.jesp.2021.104199

Moore, J. T., Luna-Pinto, C., Cox, H., Razi, S., St. Louis, M. E., Ricaldi, J. N., & Liburd, L. (2022). Promoting health equity during the COVID-19 pandemic, United States. *Bulletin of the World Health Organization*, *100*(2), 171–173. https://doi.org/10.2471/BLT.21.286074

Nkomo, S. M. (1992). The Emperor Has No Clothes: Rewriting "Race in Organizations." *The Academy of Management Review*, *17*(3), 487–513. https://doi.org/10.2307/258720

Nwanji, N. (2023, September 22). *Over 76% Of Chief Diversity Officers Are White While Just Under 4% Are Black, Report Says*. Yahoo Finance. https://finance.yahoo.com/news/over-76-chief-diversity-officer-185454530.html

Our Focus Areas. (n.d.). RWJF. Retrieved May 13, 2024, from https://www.rwjf.org/content/rwjf-web/us/en/our-vision/focus-areas.html

Rappleye, E. (2019, October 8). *Boards are tired of focusing on diversity, PwC finds*. https://www.beckershospitalreview.com/hospital-management-administration/boards-are-tired-of-focusing-on-diversity-pwc-finds.html

Ray, V., & Purifoy, D. (2019). The Colorblind Organization. In *Race, Organizations, and the Organizing Process* (Vol. 60, pp. 131–150). Emerald Publishing Limited. https://doi.org/10.1108/S0733-558X20190000060008

Roche, C., & Passmore, J. (2023). "We do not see color!": How executive coaching can help leaders to create inclusive corporate cultures by acknowledging structural racism in its ecosystem. *Consulting Psychology Journal*, *75*(1), 5–31. https://doi.org/10.1037/cpb0000232

Sage Reference—The SAGE Handbook of Organizational Institutionalism. (n.d.). Retrieved February 13, 2024, from https://sk.sagepub.com/reference/sage-handbook-of-organizational-institutionalism-2e/i5757.xml

scott institutions and organizations—Google Search. (n.d.). Retrieved February 13, 2024, from https://www.google.com/search?gs_ssp=eJzj4tVP1zc0TC6KN6ssjk8zYPRSKU7OLylRyMwrLsksKS3JzM8rVkjMS1HIL0pPzMusSgSLAADtsxN-&q=scott+institutions+and+organizations&oq=scott+instituions&gs_lcrp=EgZjaHJvbWUqCQgBEC4YDRiABDIGCAAQRRg5MgkIARAuGA0YgAQyCQgCEAAYDRiABDIICAMQABgNGB4yCggEEAAYCBgNGB4yCggFEAAYCBgNGB4yCggGEAAYCBgNGB4yCggHEAAYCBgNGB4yCggIEAAYCBgNGB7SAQg1NjM2ajBqN6gCALACAA&sourceid=chrome&ie=UTF-8

Silvera, G. A., Erwin, C. O., & Garman, A. N. (2023). A Seat at the Table: An Examination of Hospital Governing Board Diversity, 2011–2021. *Journal of Healthcare Management*, *68*(2), 132–142. https://doi.org/10.1097/JHM-D-22-00068

Sommers, B. D., & Haffajee, R. L. (2021). Federal Policies to Expand Health Insurance Coverage During the COVID-19 Pandemic and Beyond. *JAMA Health Forum*, *2*(11), e214608. https://doi.org/10.1001/jamahealthforum.2021.4608

Stainback, K., & Tomaskovic-Devey, D. (2012). *Documenting Desegregation: Racial and Gender Segregation in Private Sector Employment Since the Civil Rights Act*. Russell Sage Foundation. https://www.jstor.org/stable/10.7758/9781610447881

Terry Ellis, N. (n.d.). *Black women in leadership are finding themselves on the "glass cliff" | CNN*. Retrieved November 15, 2023, from https://www.cnn.com/2022/12/17/us/black-women-glass-cliff-reaj/index.html

The Influence of Code-Switching on Black Women Leaders: A Phenomenological Study - ProQuest. (n.d.). Retrieved November 15, 2023, from https://www.proquest.com/openview/5c5068841a70fb624e29b318a2c87451/1?pq-origsite=gscholar&cbl=18750&diss=y

The Underrepresentation of African American Women in Executive Leadership: What's Getting in the Way? - ProQuest. (n.d.). Retrieved November 15, 2023, from

https://www.proquest.com/openview/ff55ac0be8998b5ef30f0e60ef02420f/1?pq-origsite=gscholar&cbl=1056382

Thornton, P. H., & Ocasio, W. (1999). Institutional Logics and the Historical Contingency of Power in Organizations: Executive Succession in the Higher Education Publishing Industry, 1958– 1990. *American Journal of Sociology*, *105*(3), 801–843. https://doi.org/10.1086/210361

Watkins, S. (2013). *The Black O: Racism and Redemption in an American Corporate Empire*. University of Georgia Press.

Watkins-Hayes, C. (2009). Race-Ing the Bootstrap Climb: Black and Latino Bureaucrats in Post-Reform Welfare Offices. *Social Problems*, *56*(2), 285–310. https://doi.org/10.1525/sp.2009.56.2.285

Weissman, J. S., Adler, R. R., Betancourt, J., Tan-McGrory, A., Lewis, J. A., DesRoches, C. M., Pomer, A., Singh, E., Liebig, A., Ilkhani, S., & Diviti, S. (2023). How Hospitals Are Addressing The Effects Of Racism: A Mixed-Methods Study Of Hospital Equity Officers: Study examines hospital equity officers. *Health Affairs*, *42*(10), 1402–1410. https://doi.org/10.1377/hlthaff.2023.00474

Wingfield, A. H. (2009). RACIALIZING THE GLASS ESCALATOR: Reconsidering Men's Experiences with Women's Work. *Gender and Society*, *23*(1), 5–26.

Wingfield, A. H. (2010a). Are Some Emotions Marked "Whites Only"? Racialized Feeling Rules in Professional Workplaces. *Social Problems*, *57*(2), 251–268. https://doi.org/10.1525/sp.2010.57.2.251

Wingfield, A. H. (2010b). Are Some Emotions Marked "Whites Only"? Racialized Feeling Rules in Professional Workplaces. *Social Problems*, *57*(2), 251–268. https://doi.org/10.1525/sp.2010.57.2.251

Wingfield, A. H., & Chavez, K. (2020). Getting In, Getting Hired, Getting Sideways Looks: Organizational Hierarchy and Perceptions of Racial Discrimination. *American Sociological Review*, *85*(1), 31–57. https://doi.org/10.1177/0003122419894335

Wingfield, A. H., Hordge-Freeman, E., & Smith-Lovin, L. (2018). Does the Job Matter? Diversity Officers and Racialized Stress. In *Race, Identity and Work* (Vol. 32, pp. 197–215). Emerald Publishing Limited. https://doi.org/10.1108/S0277-283320180000032013

Wooten, M. (20190520BST00:00:00). *Race, Organizations, and the Organizing Process*. Emerald Publishing Limited.

Wooten, M. E., & Couloute, L. (2017). The production of racial inequality within and among organizations. *Sociology Compass, 11*(1), e12446. https://doi.org/10.1111/soc4.12446

Chapter 5 Conclusion

In this dissertation, I examine whether healthcare organizations are genuinely advancing health equity and prioritizing diversity in their administrative workforce, or if their efforts are merely performative. While scholars have long studied race and racism in the workplace and healthcare—particularly their impact on the clinical workforce—the focus has often been on physicians and nurses of color, especially during crises like the COVID-19 pandemic. This research highlighted the racism these professionals face from patients and employers, affecting both workforce morale and patient care. However, less attention has been given to how racial and structural biases are ingrained in healthcare organizations and how these dynamics impact the administrative workforce. I argue that the lack of research in this area has constrained our understanding of recruitment and retention of a diverse administrative workforce, diversity, equity, and inclusion (DEI) and health equity strategy development, and the training of early-career professionals.

The events of 2020, including the COVID-19 pandemic and the killing of George Floyd, forced the nation to confront systemic racism and its impacts. While the pandemic exposed disparities, with Black, Latino, and Native American communities disproportionately affected, there was also a notable increase in anti-Asian racism. The nationwide protests and calls for police reform led many organizations, including those in healthcare, to pledge anti-racist practices. Despite these pledges, the lack of diversity in the healthcare workforce remains stark: about 98% of hospital CEOs are white, the average hospital board is 87% white, and less than 5% of physicians in America identify as Black. Research on how healthcare organizations uphold whiteness and the implications for organizational culture is still developing. Additionally, confusion between health equity and DEI continues to obscure progress in these areas.

In my first paper, I assess the integration of DEI and health equity principles in healthcare administrative fellowship programs. This is the first such assessment of these programs' commitment to

these principles in training their fellows. I also analyze administrative job advertisements to uncover any racialized or gendered expectations. My second paper examines how occupational roles and hierarchical positions, especially within middle management, influence perceptions of the success of health equity initiatives in healthcare organizations. The third paper explores how organizations use race and racism in their strategic goal-setting for DEI and health equity, and how this affects Black executive leaders in these roles, impacting their effectiveness.

The growing literature on health equity and DEI in healthcare represents a crucial development, especially during a time in the United States when there have been active efforts to dilute or erase DEI and health equity initiatives. The academic community's efforts to understand what effectively "doing" health equity and DEI work looks like in healthcare organizations acknowledges that these organizations are expected to address the public's demand for anti-racist workplaces. However, the current body of work remains woefully inadequate.

Existing research has largely focused on health equity and DEI within the context of medical doctors, medical training, and their impact on the medical workforce, often overlooking the healthcare administrative workforce. This administrative sector, crucial for implementing and actualizing DEI and health equity policies in real time, has been neglected. Critical questions about what incoming management trainees learn, the roles of Chief DEI and Health Equity Officers, and the experiences of their direct reports (if they have any staff) remain largely unanswered.

This dissertation specifically addresses these gaps, aiming to reveal the significant work needed to better understand the state of DEI and health equity efforts within the U.S. healthcare system. Using a qualitative approach, this research seeks to amplify employee voice, identify gaps in recruitment and retention, pinpoint organizational policy issues, and call for more robust guidance to support both diversifying the workforce and retaining the diverse talent already in place.

Structural Issues along the Career Journey

In Chapter 2, I found that while organizations broadly demonstrate their commitment to health equity and DEI through mission statements and visible pledges or badges, healthcare administrative fellowship programs—designed to nurture and develop future leaders—fail to reflect these commitments in their job descriptions. Among the hundreds of fellowship job ads analyzed, very few programs list health equity or DEI as focus areas, especially when compared to more traditional rotations like strategy, human resources, and finance. Equally concerning, these job ads often feature racialized and gendered language that can hinder recruitment. Within these ads, expectations about what constitutes a "culture fit," "professionalism," and the traits of a "leader" are embedded, potentially perpetuating biases.

These findings highlight a disconnect in administrative fellowship programs, which are promoted by healthcare management and policy departments as prestigious opportunities for developing strong healthcare leaders. Despite this, the job advertisements—key documents for prospective applicants—do not emphasize health equity or DEI as crucial elements of the training and development process. This disconnect can be understood through the lens of the theory of racialized organizations. According to this theory, organizations are not neutral entities but are instead shaped by and perpetuate racial hierarchies and biases embedded in their structures, practices, and cultures. In racialized organizations, these biases manifest in subtle yet pervasive ways, influencing decision-making processes, cultural norms, and expectations.

In the context of healthcare administrative fellowships, the lack of emphasis on health equity and DEI in job descriptions reflects a broader issue within the organization's racialized framework. The absence of these critical focus areas signals that the programs may not fully challenge or address the systemic inequities that exist within healthcare. By failing to prioritize DEI and health equity, these fellowships reinforce a status quo that maintains existing power dynamics and barriers, rather than fostering an environment that genuinely supports diverse perspectives and equitable practices.

At the early career stage, this omission has significant implications. When foundational programs like fellowships do not integrate DEI and health equity principles, they risk perpetuating a narrow, exclusionary culture that can deter diverse candidates and limit their professional growth. This lack of focus may also impede the development of future leaders who are equipped to challenge and transform systemic inequities. Therefore, it is crucial for fellowship programs to embed these principles from the outset to ensure that they contribute to a more inclusive and equitable healthcare leadership pipeline.

In Chapter 3, I shift the focus from early-career professionals to mid-career individuals. Middle managers exhibit some skepticism about their organizations' commitment to health equity, yet they generally express positivity and satisfaction with their roles and the progress their organizations are making toward advancing health equity. These middle managers often speak highly of their executive leadership teams, frequently noting that the introduction of positions such as Chief Diversity Officer or Chief Health Equity Officer is a step in the right direction. They express enthusiasm about the prospect of engaging in more meaningful work under the leadership of these officers.

This stands in stark contrast to the findings in Chapter 4, where the overwhelming majority of Black executive leaders report dissatisfaction, feelings of tokenism, and a lack of strategic guidance, funding, and staffing support in their roles. These leaders often feel pressured to achieve significant results without adequate resources. Over the last several years, there has been significant discussion about DEI leaders, less about health equity leaders, and virtually nothing about those who hold blended DEI and health equity responsibilities. This comes at a time when healthcare has been labeled "the new battlefront for anti-diversity, equity, and inclusion (DEI) attacks" (Blackstock, Isom, & Legha, 2024).

The theory of racialized organizations has been key to the theoretical understanding of this highly polarizing topic. This theory provides a crucial lens for examining why we see the patterns and behaviors within organizations that we do, particularly regarding DEI and health equity initiatives. Often, discussions around these topics lack a theoretical framework to explain the underlying reasons for

observed phenomena. The theory of racialized organizations helps elucidate how race and racism are embedded within organizational processes and structures, influencing the experiences and perceptions of both middle managers and Black executive leaders.

The final two chapters of my dissertation intentionally examine how middle managers perceive organizational progress towards advancing health equity. Additionally, they explore how organizations use race strategically to convey to the broader public that they are addressing DEI and health equity issues. Often, this involves hiring a Black leader to spearhead these initiatives without providing the necessary support or resources for them to succeed.

Implications for Policy, Theory, and Practice

The findings from Chapters 2, 3, and 4 reveal important insights into how healthcare organizations approach health equity and DEI, highlighting the need for targeted interventions across policy, theory, and practice. As the political climate increasingly challenges the validity and importance of DEI and health equity efforts, it is crucial to understand the broader implications of these findings and their impact on the future of healthcare leadership and organizational culture. Addressing these gaps requires a multifaceted approach that not only protects and advances DEI initiatives but also refines theoretical frameworks and improves practical implementations. The following sections outline key implications for policy, theory, and practice based on the research findings.

5.1.1.1 Implications for Policy

1. Protection of DEI and Health Equity Efforts: The current political climate poses a significant threat to DEI and health equity initiatives, with active efforts to undermine these critical areas. In response, it is essential for policymakers and organizational leaders to advocate vigorously for the protection and advancement of DEI and health equity efforts. This involves not only maintaining existing DEI offices and positions but also ensuring they are adequately resourced and empowered. Organizations should

focus on reinforcing policies that protect DEI programs from political interference and ensuring that these initiatives remain a priority regardless of shifting political landscapes.

2. Strengthening Focus and Accountability: Organizations must strengthen their focus on DEI and health equity by setting clear, measurable goals and holding themselves accountable to these objectives. This includes developing robust mechanisms for tracking progress, reporting on outcomes, and being transparent about both successes and challenges. Active advocacy should also involve building coalitions with other organizations and stakeholders to support and sustain DEI efforts, thereby creating a united front to counteract any attempts to diminish these initiatives.

5.1.1.2 Implications for Theory

1. Evolving the Theory of Racialized Organizations: The theory of racialized organizations, first articulated in 2019, is still in its early stages of development and offers a promising framework for understanding how organizations perpetuate racial hierarchies and biases. However, there is a significant need for further exploration and application of this theory, especially within the context of healthcare organizations. While the theory provides valuable insights, it must be expanded to fully address its implications for DEI and health equity work. This dissertation underscores the necessity of more comprehensive literature and analysis to understand how racialized structures affect the diversification of the workforce and other related issues. As the role of race in organizational contexts continues to gain attention, there is a unique opportunity to apply and refine theoretical perspectives to move beyond surface-level discussions and develop a deeper theoretical grounding for addressing the systemic challenges identified in this research.

5.1.1.3 Implications for Practice

1. Redesigning Fellowship Programs: Healthcare administrative fellowship programs should be redesigned to integrate health equity and DEI principles more thoroughly. This involves embedding these

principles into program curricula, job descriptions, and selection criteria. Programs should include specific training focused on health equity and DEI, ensuring that these areas are not just peripheral but central to the development of future leaders. Additionally, fellowship programs should regularly review and update their practices to reflect evolving best practices and feedback from diverse participants.

2. Supporting Middle Managers in Health Equity Work: Middle managers play a critical role in advancing health equity but often face ambivalence and uncertainty about how to implement effective DEI strategies. To address this, organizations should provide targeted support to help middle managers navigate these challenges. This includes offering training on how to handle ambivalence, providing clear guidelines and resources for DEI and health equity work, and creating forums for sharing best practices and discussing challenges. Ensuring that middle managers have the tools and support they need can prevent stagnation and inaction, which can otherwise hinder progress in health equity initiatives.

3. Black executive leaders in DEI and health equity roles face unique and significant challenges that demand targeted and substantial support from their organizations. It is imperative that organizations move beyond mere performative gestures and genuinely commit to the success of these leaders by implementing the following measures:

- **Establish Robust Mentorship Programs:** Create structured mentorship programs that pair Black DEI/HE leaders with experienced executives who can provide guidance, support, and advocacy. These programs should focus on career development, strategic planning, and navigating organizational politics.
- **Provide Comprehensive Professional Development:** Offer continuous professional development opportunities tailored to the needs of Black DEI/HE leaders. This should include leadership training, workshops on managing DEI initiatives, and access to industry conferences and networks.

- **Allocate Dedicated Resources:** Ensure that Black DEI/HE leaders have access to dedicated budgets and resources necessary to implement effective DEI and health equity programs. This includes funding for initiatives, hiring staff, and acquiring necessary tools and technologies.
- **Address Systemic Barriers:** Actively work to dismantle systemic barriers that impede the effectiveness of Black DEI/HE leaders. This involves critically examining and restructuring organizational policies and practices that perpetuate inequality and undermine DEI efforts.
- **Set Realistic Expectations:** Develop clear and achievable goals for DEI and health equity initiatives, and ensure that Black leaders are not burdened with unrealistic expectations. Recognize the long-term nature of meaningful DEI work and provide the necessary time and support for sustainable progress.
- **Foster an Inclusive Organizational Culture:** Cultivate an organizational culture that truly values diversity, equity, and inclusion. This means fostering an environment where Black DEI/HE leaders feel supported, respected, and empowered to drive change without facing resistance or tokenism.
- **Hold Leadership Accountable:** Implement accountability mechanisms to ensure that top executives and board members actively support and participate in DEI and health equity efforts. This includes setting DEI performance metrics for all leaders and regularly reviewing progress.

Organizations that are serious about advancing DEI and health equity must recognize that hiring Black leaders is just the beginning. Without the proper support, these leaders are set up to fail. By providing targeted support and addressing systemic challenges, organizations can not only retain talented Black DEI/HE leaders but also harness their expertise to drive genuine and lasting change in health equity efforts.

Future Research

While this dissertation focused on the context of healthcare systems, future research should expand to examine healthcare organizations within corporate settings, such as managed care organizations (MCOs). These entities face unique challenges, including investor expectations, operating within for-profit frameworks, and navigating complex regulatory environments. Understanding how these organizations recruit diverse talent and advance health equity is critical, especially given the prevailing negative perceptions of healthcare insurers as convoluted and indifferent to members' needs.

One promising area for exploration is the role of managed care organizations in promoting DEI and health equity. These organizations are increasingly under scrutiny due to federal mandates from entities like the Centers for Medicare & Medicaid Services (CMS), which require them to articulate and implement strategies for addressing health equity. The CMS Health Equity Index, for instance, rewards organizations that make significant strides in health equity, encouraging transparency and accountability. MCOs must prepare for this by conducting thorough assessments of their current health equity initiatives, setting measurable goals, and demonstrating progress in reducing disparities in care.

Similarly, the National Committee for Quality Assurance (NCQA) Health Equity Accreditation is becoming an industry standard, exerting substantial pressure on organizations to adopt comprehensive health equity practices. Achieving this accreditation involves rigorous evaluation of an organization's policies, procedures, and outcomes related to health equity. This accreditation not only enhances an organization's reputation but also ensures that they are committed to providing equitable care to all members, thereby improving health outcomes and reducing disparities.

.Investigating how MCOs respond to these mandates and the effectiveness of their DEI and health equity initiatives can provide valuable insights. This research could uncover best practices and highlight areas needing improvement, contributing to a broader understanding of how corporate healthcare organizations can better serve diverse populations and improve health outcomes. Such studies could also

explore the impact of regulatory pressures on organizational behavior, the allocation of resources, and the support structures available to DEI and health equity leaders within these companies.

By examining the intersection of corporate healthcare and health equity, future research can help build more inclusive and effective organizational practices. This, in turn, can lead to more equitable health outcomes and improved trust between healthcare insurers and the communities they serve.

Appendices

Appendix A: Appendix A Chapter 2 Supplementary Materials

Codebook

Category		Definition
Fellowship Description		A detailed overview of the fellowship program, including its objectives, structure, and focus areas. This provides information about the program's purpose, activities, and opportunities for participants.
Subcode	Fellowship Type (Single-Focused) • Finance • Strategy • Operations • Health Equity/DEI • Human Resources • Quality Improvement • Info Technology • Supply Chain Multi-Functional • Multi-Functional Specialized Rotations • Multi-Functional Executive Track • Multi-Functional Operations • Multi-Functional Clinical • Multi-Functional Strategy & Analytics	Categorizes the fellowship program into specific types or categories based on common characteristics or areas of specialization (e.g., strategy-focused, finance, operations); See Appendix for Operational Definitions of Each

	• Multi-Functional Policy & Advocacy	
Name of Organization		The official name of the organization offering the fellowship program.
Fellowship Title		The specific title or name given to the fellowship program.
Fellowship Year		Specifies the year or years during which the fellowship program is offered
Fellowship Requirements		Outlines the eligibility criteria and prerequisites that applicants must meet to be considered for the fellowship program.
Number of Positions Offered		Indicates the quantity of fellowship positions available within a particular program
Fellowship Design		Describes the structure and format of the fellowship program, including elements such as the rotational schedule and the length of the program.

Subcode	Rotational Schedule	Indicates if the fellowship program follows a rotational model, where participants are exposed to different departments or areas within the organization during their training
Subcode	Length of Program	Specifies the duration or length of the fellowship program (e.g., 1 year, 2 years, etc)
Organizational Characteristics		Highlights aspects related to diversity, equity, and inclusion (DEI) or health equity within the fellowship program.
Subcode	Diverse patient population	Indicates if the fellowship program emphasizes that their organization serves diverse patient populations to address health disparities, or provide high quality care
Subcode	Diverse workforce population	Indicates if the fellowship program or organization emphasizes building a diverse workforce and promoting inclusivity within the organization
Subcode	Organizational commitment to Health Equity (HE)	Reflects the organization's dedication to addressing health equity issues within its policies and practices
Subcode	Organizational commitment to Diversity Equity and Inclusion (DEI)	Reflects the organization's commitment to fostering diversity, equity, and inclusion throughout its operations
Subcode	Organization Mission and Values	Describes the organization's guiding principles and values that shape its overall mission and operations
Subcode	Organization Type	Categorizes the type of organization (e.g., healthcare system, academic institution, non-profit organization, etc)

Operational Definitions for Fellowship Type

Functional Area	Operational Definition

Ambulatory Services	Fellowships in ambulatory services focus on managing and optimizing outpatient care settings, patient flow, and care delivery in outpatient facilities and clinics.
Finance	Fellowships in finance concentrate on providing participants with opportunities to develop financial management skills, including budgeting, and financial analysis, within healthcare organizations.
Hospital Operations	Fellowships in hospital operations center on understanding and managing the overall operations of a healthcare facility, ensuring efficient and effective delivery of services and patient care.
Nursing Administration	Fellowships in nursing administration focus on developing nursing leadership skills, managing nursing staff, and enhancing patient care services within healthcare organizations.
Research Administration	Fellowships in research administration involve managing and coordinating research projects, grants, and compliance within healthcare institutions and advancing research initiatives.
Health Equity	Fellowships in health equity emphasize initiatives and programs aimed at addressing health disparities and promoting equitable healthcare access and outcomes for all populations.
Diversity, Equity, and Inclusion	Fellowships in DEI focus on promoting diversity, equity, and inclusion within healthcare organizations, fostering inclusive environments, and addressing disparities in healthcare delivery.
Revenue Cycle Management	Fellowships in revenue cycle management center on optimizing the financial aspects of healthcare operations, including billing, coding, and reimbursement processes for healthcare services.
Human Resources	Fellowships in human resources concentrate on talent management, recruitment, employee relations, and HR policy development to support the effective management of the healthcare workforce.

Health Policy	Fellowships in health policy involve understanding and influencing healthcare policies and regulations, advocating for health-related initiatives, and shaping healthcare public policy.
Governance	Fellowships in governance focus on understanding healthcare governance structures, compliance, and legal frameworks that guide decision-making within healthcare organizations.
Marketing and Communications	Fellowships in marketing and communications center on promoting healthcare services, managing brand reputation, and implementing effective communication strategies to engage patients and stakeholders.
Quality Improvement	Fellowships in quality improvement concentrate on data-driven initiatives to enhance healthcare processes, patient safety, and clinical outcomes, with a focus on continuous performance improvement.
Information Technology and Digital Health	Fellowships in IT and digital health involve managing and implementing health information systems, data analytics, and digital technologies to support healthcare organizations' technological needs.
General Management	Fellowships in general management provide participants with a broad exposure to various functional areas within the healthcare organization, preparing them for leadership roles and overall administrative responsibilities.
Strategy	Fellowships in strategy focus on strategic planning, market analysis, business development, and the formulation and implementation of organizational strategies to achieve long-term objectives and growth.
Supply Chain	Fellowships in supply chain focus on logistics, procurement, inventory management, and supply chain optimization to ensure a smooth flow of resources and materials within healthcare organizations.

Operations	Fellowships in operations emphasize the understanding of healthcare operations and workflow, process improvement, quality management, and operational efficiency to optimize the delivery of healthcare services.
Private Diagnostic Care	Fellowships in private diagnostic care concentrate on managing and optimizing diagnostic and imaging services in private healthcare settings, and developing skills in service delivery and patient experience.
ROTATIONAL BREAKDOWN:	
Multi-Functional Specialized Rotations	This program offers diverse and targeted rotations in specific areas of healthcare administration, allowing participants to gain in-depth knowledge and skills in various specialized domains, such as finance, human resources, facilities management, or others
Multi-Functional Service Leadership	MFSL focuses on developing leaders who excel in providing exceptional service delivery and patient care. Participants engage in rotations that emphasize service improvement, patient experience, and effective leadership in healthcare settings.
Multi-Functional Executive Track	MFET is designed for aspiring healthcare executives. It provides participants with a comprehensive understanding of executive-level responsibilities through rotations in areas such as strategic planning, financial management, policy development, and organizational leadership
Multi-Functional Operations Focus	MFOF concentrates on operational efficiency and effectiveness in healthcare administration. Participants rotate through various departments to gain insights into streamlining processes, optimizing resource utilization, and enhancing overall operational performance.
Multi-Functional Clinical Experience	MFCE is tailored for healthcare administrators seeking a deeper understanding of clinical aspects. Participants engage in rotations that offer exposure to clinical settings, medical staff management, patient care coordination, and healthcare quality improvement
Multi-Functional Strategy & Analytics	MFSA focuses on the integration of strategic decision-making and data analytics in healthcare administration. Participants explore rotations that involve strategic planning, market analysis, and leveraging data insights for organizational growth and improvement.

Multi-Functional Policy & Advocacy	MFPA is designed to foster expertise in healthcare policy development and advocacy. Participants rotate through roles involving policy analysis, government relations, and community engagement to understand and influence healthcare policy decisions.

Appendix B: Chapter 3 Supplementary Materials

Interview Script
Sep 6, 2022

Introduction
Thank you for taking the time to participate in this interview.

I'm Simone Singh, an associate professor at the University of Michigan and the PI on this study. Also on the call is Cherie Conley, a postdoc in the School of Nursing at the University of Michigan.

This interview will last less than an hour.

As I mentioned in the introduction email, we are conducting a research project on the factors and processes that influence nonprofit hospitals' ability and willingness to address equity and structural racism through community benefit.

With your permission, I would like to record today's phone call so that we can focus our full attention on the conversation rather than taking notes. The recording will be recorded in a secure platform approved by our University, and we are always happy to pause the recording at any time. Do I have your permission to record the interview?

Interview Questions

I. Hospital/Health System Information

Q: Can you tell me a little about your hospital/health system?

Prompts:
- Number of beds
- Rural Code/location
- Teaching or Non-Teaching
- Part of a Health System
- Patient Population
- Surrounding Community
- Community Benefit as percent of operating cost
- Community benefit category allocation
- Payer mix
- Disproportionate Share Hospital
- Medicaid Expansion State
- State Community Benefit Laws?
- Mission, vision, values

II. Interviewee

Q: Can you tell me a little more about what you do/your position with ABC hospital/health system?

Prompts:
- Position
- No years in position
- No years with hospital/health system
- Tell me about your position as it relates to community benefits
- Who do you work with to design and implement community benefit programs?

III. Equity, social and structural determinants and Community Benefit

Introduction: We would like to know more about your community benefit programs. Specifically, we are interested in your hospital/health system's overall process of designing and implementing programs and how your organization incorporates equity and/or the social determinants of health into your process and programs.

Q: Can you give me a brief overview of your process for designing and implementing CB process/projects?

Q: Can you tell me about some of your community benefit initiatives? Community building? Community health improvement?

Prompts:
- Clinical care vs. community focused work
- SDOH related activities
- Upstream factors
- Hiring, investing, purchasing local
- Anchor institution?

Q: We are specifically interested in how your organization incorporates equity and/or the social determinants of health into the CB process and CB programs. Can you tell me if there is a definition or framework that your organization uses to guide the integration of equity and/or the social determinants into the CB process?

Prompts:
- If yes, ask for more detail: What language has your system adopted? Where is it seen? What framework is used, if any?
- If no: Has equity/SDOH come up as you have discussed CB? Have you heard terms/talked about it?

If interviewee's organization has integrated equity/SDOH into CB process:

Next, I'd like to talk about some of the more specific aspects of designing and implementing community benefits and incorporating equity and social and structural determinants.

Equity and Community Benefit – Conceptual Model Domains	Questions	Equity Prompts
Organizational readiness factors (Weiner, CFIR) **-Context/setting, efficacy and commitment**	What are some of the driving factors that influence your organization's ability to invest in community benefits? Building? Internal: Leadership Culture Budget Buy-in Technical assistance Past experiences External: State/federal policies Social/current events Peer institutions Community demographics What about organizational willingness or enthusiasm? Leadership Disparities Peer pressure Hospital Board What types of changes have there been in willingness or ability over time?	Are health inequities data collected and considered? Are racial bias and social patterns considered? Are structural factors considered?
Equity program design process (Rational Choice Model) **-Decision making process for program selection and design**	How does your team decide on the community benefit allocation? Identify the problem Develop decision criteria Alternatives – generate, evaluate, choose How do you decide how much should be allocated for community health improvement and community building activities? How do you decide on which community building activities to implement? Evidenced based programs?	Are community experiences and knowledge used? How are communities experiencing disinvestment and racism prioritized?

Implementation planning process (EQUIR)	Tell me about how you plan program implementation? Community partnerships Engage stakeholders How do you identify resources? What incentives are identified? Are barriers identified? Are strategies to overcome barriers identified?	Are racial bias and social patterns considered? Are structural factors considered? Are community experiences and knowledge used? How does planning incorporate: Sustainability Acceptability Feasibility Appropriateness Coverage Fidelity
Program Implementation process and persistence (EQUIR; CFIR)	What is the process of going from planning to implementation of equity focused programs? Driving factors Champions Partnerships Clear Plan Timeline Barriers Facilitators	
Evaluation process (EQUIR)	Who designs your evaluation measures? What are important factors to consider when deciding what measures and outcomes to measure and track? Long or short term Actionable	Are social and structural factors used to guide findings/ Are potential impacts of community benefit programs on race inequities considered in evaluation? Are outcome measures tied to equity data?

Q: In your experience, what are the most important facilitators to integrating equity?

Q: In your experience, what are the biggest challenges to integrating equity?

Q: Can you walk me through an example of a community program that has been implemented and the process used to design, implement and evaluate it?

Q: We're also interested in what happens when it is difficult to design and move programs through to implementation. Can you share another example of when a program was not successfully implemented and the factors behind that outcome?

Q: What else would you like to share about community benefit and community building and integrating equity?

If interviewee's organization has not integrated equity/SDOH into CB process:

Incentive
Thank you so much for your participation in this interview. We would like to offer you a $50 incentive for your time today. You can use the incentive for yourself or for your organization. Would you like to receive the incentive?

If yes: Great - in order to process the incentive, we will need an email address for sending you the electronic gift card. I will turn off the recording so we do not record your email address.
Thank you. We will process the incentives as soon as possible, and you will be receiving a gift card in the next 4-6 weeks.

CODEBOOK

Perceived Commitment	
Executive Leadership	Participants' perceptions of the commitment demonstrated by leaders and upper management to health equity. This involves the prioritization, support, and advocacy for health equity initiatives at the highest levels of the organization, including strategic decision-making and resource allocation.
Organizational Level	Participants' perceptions of their organization's overall dedication and actions toward achieving health equity. This includes the organization's policies, culture, and systemic efforts to address disparities and promote equitable health outcomes for all populations.
Individual Level	Participants' perceptions of their personal commitment to health equity and their ability to effectively perform their role in advancing these efforts as middle managers. This includes their motivation, understanding of health equity principles, and confidence in implementing strategies to reduce disparities within their scope of influence.
Strategy	
Health Equity Strategic Development	An exploration of the specific strategies employed by participants to promote health equity within their departments. This encompasses the planning,

	implementation, and integration of health equity practices, programs, and policies tailored to address the unique needs of the populations served.
Resources	
Financial Support	An assessment of the financial resources available to participants to support health equity initiatives. This includes budget allocations, funding opportunities, grants, and financial investments dedicated to addressing health disparities and promoting equitable health outcomes.
Staff Personnel	An assessment of the staffing resources available to participants to support health equity initiatives. This includes the availability and qualifications of personnel, training programs, workload distribution, and collaborative efforts within the organization to effectively address health disparities and promote equity.
Measurement	**How does the organization measure success?**
Clear Metrics	The organization has well-defined metrics and expectations for success in the DEI or Health Equity role. There are clear, measurable goals and indicators to assess success for both the role and the organization.
Not Defined	The organization does not have clear metrics or expectations for success in the DEI or Health Equity role. Success is not well-defined, and there are no specific, measurable goals in place.

Appendix C: Chapter 3 Supplementary Materials

EMAIL TEMPLATE AND RECRUITMENT FLYER

Email - Direct Contact

Dear [Insert Name],

My name is Tiffany Cornwall [hyperlink to HSOP student profile], and I am a PhD candidate in the Department of Health Management and Policy in the Department of Health Management and Policy at the University of Michigan School of Public Health. I am writing to invite you to participate in my doctoral research study, which aims to understand the leadership experiences of senior-level leaders in DEI and health equity related roles, with particular attention to the organizational characteristics that either help or hinder progress in your role.

As a leader at the executive level, your insights and experiences are incredibly valuable to this study. Participants will be interviewed about their work experiences and potential barriers to implementing DEI or health equity strategy at their institutions.

To be eligible for participation, you should be:

- At least 18 years of age
- Currently employed at the executive-level (titles may vary) or in the most senior administrator role responsible for DEI or health equity at your organization.
- Have at least one year of experience in their respective position
- Must identify as Black/African American

If you are interested in participating, we will schedule a 45-50 minute interview through Zoom web-conferencing (cloud sharing will be disabled), and video and audio recorded solely for data collection. I assure you that the demographic data as well as the data collected from each interview will be kept confidential, and information from this study will not identify you or your institution by name. This study has been approved by the University of Michigan Institutional Review Board (HUM00235862).

If you meet the eligibility criteria and are interested in participating, please email me at tpeart@umich.edu. If you have any questions or concerns, or would like to discuss any details, feel free to contact me via phone at 347.454.1697.

I appreciate your thoughtful consideration, and I am looking forward to hearing from you.

Sincerely,
Tiffany Cornwall, MPH
PhD Candidate, Health Management and Policy

University of Michigan School of Public Health
tpeart@umich.edu

INTERVIEW GUIDE & CODEBOOK

Interview Structure

- Semi–structured interview (60 minutes)

Interviews were conducted using the following approach:

- Utilized the interview guide as a tool to facilitate the conversation, rather than strictly adhering to it as a script.
- Employed probes and follow-up questions when necessary to ensure clarity and depth of responses.
- Framed all questions in an open-ended manner, avoiding leading questions.
- Expressed gratitude and thanked the participant for their time at the conclusion of the interview.

Probes:

For more detail, ask the following questions:

Could you provide me with a specific example of that?
Tell me more about your experience with this.
How does that situation or issue make you feel?

For clarification, ask the following questions:
When you mention [term or concept], could you please elaborate or provide further insights?
It appears that you are expressing [interpretation]. Am I understanding your perspective correctly?

Introduction:

Thank you for taking time to meet with me, [introduce myself]. As a [insert title], you offer an extremely valuable perspective as an executive leader who dedicates their professional work to issues related to DEI and health equity. So, I would like to ask you some questions about your experiences as a [insert title], with particular attention to the organizational characteristics that either help or hinder progress in your role.

- *This interview is voluntary, and you are free to end it at any time or to skip any questions you would prefer not to answer. With your permission, I will record and transcribe our conversation, but what you share will only be seen by myself and a professional transcription service; any quotations that may be used will not include your name, program, or any information that could identify you. The interview will take about 30-45 minutes. Is it ok if we get started?*

Can you tell me a little bit about your background and how you became [insert title] at your organization?

Please tell me about your current role as [insert title].

- How long have you been in your position?
- What are your responsibilites?
- What activities do you undertake or oversee?

Please tell me about the history of [insert title] at your organization.

- Were you the first [insert title] or was there someone in this position before you?
- *Probe*: *Why do you believe the [insert title] was created at your organization?*
- *If the person wasn't the first, possible follow ups:* How did they approach the role? What did you want to do differently (or were asked to do differently)?

Who do you report to within the organization?

- Probe: *Do you have any staff to support your work?*
- *Follow-up:* Does this reporting structure feel right to you and the work you are trying to do?; Does your staffing level feel right to you? Why or Why not?

How do you feel your position as [insert] is perceived within the organization?

- Do you feel that you have an equal level of authority and respect as your peers in the C-suite?

Have you experienced any challenges related to censorship or restrictions on your DEI or health equity efforts within your organization or from peers?

Could you speak to the level of support you receive from the organization in your role?

- Probe: H*ow do you feel about the resources and assistance provided to help you achieve your goals? What other organizational or environmental supports need to be in place for success?*

How was the strategic framework or plan for your position developed, and what role did you play in its creation? *Or*, if there was no existing framework, how did you go about developing a strategy from scratch?

- Probe: *Can you discuss any organizational challenges you faced during the development of the strategic plan, and how you addressed them?; How is it informed by or integrated with broader organizational strategy?*

Can you speak to how your racial/ethnic identity has influenced your experience as a [insert title]?

- In what ways, if any, has your identity impacted your approach to this role and the initiatives you have undertaken?

What does a "good day" look like for you in your role as [insert]?

- What accomplishments or milestones would make you feel particularly satisfied or fulfilled?

What does a "bad day" look like?

- What challenges or obstacles might you encounter that make it difficult to achieve your goals?
- Probe: *How do you address or overcome these challenges when they arise?*

Can you define DEI and health equity for me?

- What do you see as the relationship between these?
- Do you think your organization thinks about these concepts the same way?

How does your organization measure success in terms of [DEI or Health Equity] initiatives?

- Probe: *How do you track progress towards these goals and how often are they evaluated? Do you share these results within the organization or outside?*

What are some policies or actions that you think your organization can implement to show further commitment to DEI or health equity?

What do you see as the future of DEI or health equity efforts within your organization?

- Probe: *What are some specific organizational goals or initiatives that you hope to see implemented in the future?*

Any further comments or insights you would like to add to the discussion?

CODEBOOK

Role	
Chief Diversity, Equity, Inclusion Officer	Individuals in this role primarily focus on fostering diversity, equity, and inclusion within the organization. Their key responsibilities involve implementing strategies to create a more diverse workforce, promoting an inclusive organizational culture, and addressing disparities related to race, gender, and other dimensions of diversity.
Chief Health Equity Officer	Individuals in this role concentrate specifically on advancing health equity initiatives. Their primary responsibilities include developing and implementing strategies to reduce health disparities, ensuring equitable access to healthcare services, and addressing social determinants of health within the organization and the broader community.
Dual-Role	Individuals in this role strategically address both Diversity, Equity, and Inclusion (DEI) and Health Equity priorities. They navigate the intersectionality of these domains, working to create an inclusive workplace while simultaneously addressing health disparities and promoting equitable healthcare practices within the organization and the broader community.
Structure	**Who do they report to?**
Reports to CEO	The Chief DEI or Equity Officer reports directly to the Chief Executive Officer or top leadership of the organization.

Reports to Human Resources	The Chief DEI or Equity Officer reports to the Human Resources department or a similar organizational unit responsible for personnel management (e.g, Chief People Officer, Chief HR Officer).
Reports to Chief Operating Officer	The Chief DEI or Equity Officer reports to the Chief Operating Officer, overseeing operational aspects of the organization.
Reports to Chief Medical Officer	The Chief DEI or Equity Officers reports to the Chief Medical officer.
Other	Any unique reporting structure not covered by the above codes can be categorized as "Other," with additional details provided in the memo.
Organizational Support	**Do they have budget/staff/buy-in?**
Comprehensive	The organization provides robust support across all aspects, including a dedicated budget, sufficient staffing, and strong leadership buy-in for DEI or Health Equity initiatives.
Limited	The organization provides limited support, with constraints in budget allocation, staffing, or leadership buy-in for DEI or Health Equity initiatives.
Varied Support	The organization's support for DEI or Health Equity initiatives varies across different aspects, such as having budget and staffing support but limited leadership buy-in, or vice versa.
No Support	The organization provides no support. Individuals have no budget, no staff, no leadership-buy in.
Leadership Transition	
Inaugural	First to ever hold the position at their organization.
Successor	Someone held the position before them.
Strategy	
Guidance	Code when the officer says they co-developed the strategic framework with leadership (e.g., received input, preferences, suggestions to influence the direction and content)
Created	Code when the officer had to develop a strategic framework independently
Enhancement	Code when the officer entered a role where someone else was previously responsible for DEI or HE initiatives, and they were hired to improve, build upon, or enhance the existing framework.

Career Satisfaction	**Do they enjoy their position?**
Enjoyment	Captures positive feelings and enjoyment from their responsibilities and contributions
Regret	Indicates sentiments of regret or dissatisfaction regarding their decision to take on the leadership role
Mixed	Mixture of both positive and negative feelings about their role
Barriers	
Performativity	Barriers related to reluctance among employees or leadership to embrace DEI or health equity efforts, examples of performativity
Censorship	Barriers related to the organization imposing restrictions on the communication or expression of DEI or health equity-related efforts. Examples may include eliminating the word racism from written text.
No Barriers	The interviewee states that they are not experiencing any organizational barriers to success in the role or executing their strategic priorities.
Racism	
	Barriers related to various types of racism (note in memo) Examples might include: 1) Institutional racism: interviewee describes systemic structures, policies, or practices that perpetuate racial disparities or 2) Interpersonal racism: prejudgment, bias, or discrimination from a colleague, patient, etc
Policy	
	Barriers related to both internal or external policies. Examples may include legislative bans on specific DEI language or constraints imposed by external governing bodies.
Measurement	**How does the organization measure success?**
Clear Metrics	The organization has well-defined metrics and expectations for success in the DEI or Health Equity role. There are clear, measurable goals and indicators to assess success for both the role and the organization.
Not Defined	The organization does not have clear metrics or expectations for success in the DEI or Health Equity role. Success is not well-defined, and there are no specific, measurable goals in place.

Partially Defined	The organization has some metrics and expectations for success in the DEI or Health Equity role, but there is room for improvement or further clarification. The metrics could be strengthened to provide a clearer picture of success.

1. **Organizational-Level Commitment:** Participants' perceptions of their organization's overall commitment to health equity efforts.
2. **Executive-Level Commitment:** Participants' perceptions of their leaders' or upper management's commitment to health equity.
3. **Individual-level Commitment:** Participant's perceptions of their commitment to health equity and ability to successfully do their role as a middle manager
4. **Description of Health Equity Strategy:** Exploring the strategies employed by participants to promote health equity within their departments.
5. **Resources:** Assessing the resources available to participants, including financial support and staffing.

Measurement of Health Equity Goals: How participants measure and evaluate the success of health equity initiatives.