Strengthening the Diversity of Health Care Leaders: Approaches of a Master of Health Administration (MHA) Program

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Introduction and Background

Leadership in health care has long been dominated by individuals who do not represent nor reflect the communities they serve. While this was not necessarily intentional since that was true of many organizations in the U.S., it poses a special issue for the health care industry.

National associations such as the American College ofHealthcare Executives (ACHE) and the National Center for Health Care Leadership (NCHL) have worked to encourage the enhanced diversity of health care organizations by promoting men and women of color into leadership positions.

While the health care workforce is increasingly racially and ethnically diverse, only a small percentage of high-level health care leaders fall into this same category.

For example, according to estimates based on data from the American Hospital Association and ACHE, in 2019, 89 percent of all hospital CEOs were white (non-Hispanic orLatino) while, according to the most recent U.S. Census Bureau data, 60 percent of the population is white (non-Hispanic or Latino) .

This disparity persists despite two decades of success in attracting racially/ethnically diverse students to graduate studies in health administration. According to the Association of University Programs in Health

Administration, racial or ethnic minority students made up 43.7% of AUPHA graduate programs in the 2018–19 academic year. In addition, undergraduate programs were composed of an estimated 44.8% racial or ethnic minority students in the same year. More recent data collected by the Commission on the Accreditation of Healthcare Management Education (CAHME) suggests that41 percent of the CAHME graduate student population in the 2017–2018 academic year was nonwhite. (ACHE, 2020).

University of Phoenix (UOPX) was founded as an institution of higher learning that focuses on the working adult. As a result, our students are seeking a college degree to enhance their careers, since the majority are already working. They are also usually balancing work, a family, and school.

The Master of Health Administration (MHA) program in the UOPX College ofHealth Professions was founded in 2016 with a mission to prepare early-to-mid careerists, who desire to pursue a degree while employed, with the competencies necessary to grow professionally, facilitate cross-system transformation, and engage with their communities. Compared to the total UOPX graduate student population, the MHA student population reflects a slightly higher percentage of students of color. Of 324 MHA graduating students who shared their race/ethnicity with UOPX in 2021-2022, 121 or 37.3% identified as Black/African American and 59, or 18.2%, identified as Hispanic (UOPX MHA CAHME Annual Report, 2022).

Literature Review

The concerns about the lack of representation of people of color in health care leadership positions expressed by the ACHE and the NCHL have been echoed by other professional associations such as the National Association of Health Services Executives (NAHSE), which has a predominantly Black membership, and the National Association of Latino/a Healthcare Executives (NALHE). Joint studies by the NAHSE and the consulting firm, Deloitte, have documented what strategies are working in health care organizations to expand diversity, equity, and inclusion (DEI) in the workforce, and which ones need more effort (Atkins, et al, 2021).

In 2015, the American Hospital Association Institute for Diversity and Health Equity (AHA IFDHE) surveyed over 6,000 hospital organizations about the gender, race and ethnicity of their governing boards and executive suite, along with the strategies they were pursuing to increase diversity in the workforce and decrease disparities of care (Herrin et al, 2018, p 346). Over 1,000 hospitals responded, and the results demonstrated

> …that hospitals with higher proportions of racial and ethnic minorities in executive positions and on the board reported more initiatives to reduce disparities of care than other hospitals did. This was true across different types of initiatives. Specifically, in hospitals with greater representation of minorities in the C-suite, there were increased efforts to advance equity via leadership and strategic planning, increasing workforce diversity and sensitivity to cultural issues, increasing data collection on metrics of disparities, including community outreach and engagement. (p. 541).

Diversity begins with the education programs to train the next generation of leaders in health care who reflect the populations they serve. It has been noted that theU.S. is on track to become a "Majority-Minority Nation" in the not distant future (Frey, 2020). A study by Atkins et al (2017) attempted to quantify the state of student diversity in graduate health management programs in the U.S. by using Commission on the Accreditation of Health Management Education (CAHME) statistics and statistics from the 75 accredited

programs themselves about diversity within their student population. The study reported that between 2009 and 2013, student enrollment in CAHME-accredited programs grew by 22%. However, most of that growth (96.3%) was white U.S. citizens.

Student enrollment data from 58 of the 75 CAHME-accredited programs was reviewed. In 2009, 61.2% of students were white and in 2013, 67.2% were white. It should be noted that the percentage of Black and Asian students grew throughout this period, but all other racial and ethnic minority groups declined.

The Atkins et al (2017) study utilized views from current and past presidents of the NAHSE on the need for DEI content in MHA programs as the framework for a survey question posed to MHA program directors and students. Only 28% of program directors responded with data on the DEI content of their programs. However, 43%of students responded. Only 35% of those reported seeing DEI content in their curricula, even though 53% considered the diversity of the program when deciding which school to attend.

Climbing the corporate ladder in healthcare organizations can be especially daunting for women. In an article by Stewart (2021), she states from the World Health Organization that while 25% of health care leadership roles are filled by women globally, despite being 70% of the sector workforce. Additionally, she quotes a Korn Ferry report that says women lead only 20% of U.S. hospitals, despite making up 80% of the health care workers.

However, women of color have it even worse. Women of color represent 20% of entry-level health care jobs, yet only 5% of the C-suite position in health care. Dill& Duffy (2022) also point to the fact that Black women are over represented in low-paying health care jobs, emphasizing that health care work is the intersection of racism and sexism.

A doctoral dissertation by Zaynah S.S. Camp-Fry (2021) explored the underrepresentation of Black women in health care executive leadership through qualitative research.Data was gathered through interviews with nine Black women who were in positions of leadership in health care organizations. She used two primary research questions:

a.   Which social obstacles or challenges hinder Black women'sefforts to secure executive and senior positions?

b.   What strategies have Black women employed to overcomeobstacles and challenges while pursuing executive and senior positions? (p. 51).

Dr. Camp-Fry used three major theoretical frameworks to guide her study:

a.   Intersectionality- specifically the intersection of racism and gender bias.

b.   StereotypeThreats – negative societal stereotypes can result in employeeunder-performance.

c.   UpperEchelon Theory – how an executive's values and beliefs influence organizationaldecision-making and its diversity strategy.

The results of Dr. Camp-Fry's study revealed four major categories of barriers and obstacles for Black women:

a. Racial and gender bias

b. Concrete ceiling (more rigid than the glass ceiling oftenreferred to as preventing women from attaining executive positions)

c. Stereotypes and bias

d. Microaggressions

Her research also highlighted three major strategies that help to overcome barriers and obstacles:

a. Mentorships

b. Sponsorship

c. Leadership programs

Dr. Camp-Fry's findings align with information in the literature about the importance of both mentorship and sponsorship as tools to advance careers.

Mentorship and sponsorship are powerful tools for personal success and building stronger workforces. Although they are related to one another and share some similarities, they are not, as people sometimes assume, the same thing. In reality, sponsorship can grow from a productive mentor-mentee relationship (Omadeke, 2021, para 1).

UOPX-MHA Program Structure

UOPX has from its origins utilized practitioner-faculty, that is, faculty members who are working in the fields in which they teach, rather than relying on academicians who might have little connection to the practical world that students work in. This is also true in the UOPX MHA program, where 68 practitioner faculty (as of 8/24/2023) work in the field of health care and serve as instructors for our courses.

UOPX offers students support beyond the classroom in the ways that most universities do. These include:

- Academic advisement to help students stay on track
- Access to LinkedIn Learning courses and workshops for additionalskills education
- Career Counseling to assist students in finding thecareer opportunity which meets their goals
- Alumni connections for mentorship and support

The UOPX MHA program was recently awarded a full seven-year accreditation by CAHME. This was only the second time that CAHME had visitedUOPX since the MHA program was founded in 2016. In addition to this outstanding performance, the site visit team from CAHME noted some areas of strength in the program:

- Diversity of student population and faculty
- Innovation
- IT support

The MHA student population reflects a slightly higher percentage of students of color. Because so many women of color are responsible for the financial support of their families, the program structure provides

these students with an opportunity to receive the degree they need to advance their career and still manage their life situations (Rodriguez & Cordish, 2020).

Summary

The MHA program staff completed a competency model in 2022. The MHA competency model identifies a set of 21 current and relevant competencies for working adults seeking to advance their careers in health administration. Competencies are knowledge and skills that are observable and measurable.

The competencies in the MHA competency model are organized into the following 5 domains:

- Leadership
- Communications and relationship management
- Professionalism
- Knowledge of the health care environment
- Business skills

Each domain consists of competencies, and each competency consists of standards. These competencies and standards are expected to be learned throughout the program. To measure this, there are six MHA program competency proficiency levels (levels 1–6) that should be demonstrated at an increasing level of proficiency for each standard from the beginning to the end of the program.

Competencies are also mapped to each course and specific competencies connected to elements of each course are noted for students. Each course contains three Summative Assessments that are tracked for measurement of competency mastery. Students have access to what competencies are connected to each assessment and what level of proficiency they are expected to attain.

So much of the literature on the issues that women of color and especially Black women have in moving into senior and executive positions identifies mentorships and support as an important strategy to overcoming barriers of racism and gender bias. Through our alumni and faculty networks,UOPX may be able to coach students toward identifying mentors to help them realize their career goals.

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