

Assessing the Culture of Diversity Among Professionals at a Midwestern Children's Hospital

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ABSTRACT

The ever-changing ethnic and cultural landscape of the United States drives the need to better understand diversity in its workforce. The purpose of this study was to conduct an equity audit in a midwestern children's hospital's psychosocial department to assess the perceived culture of the diversity climate. The goal of the equity audit was to uncover ways in which the department could identify needs and strengthen awareness towards the development of an inclusive environment. The equity audit was conducted in the form of a questionnaire addressing four main themes identified in workplace diversity research: physical environment, matching, communication, and leadership. Results showed that the culture of diversity appeared to be an optimistic one with many opportunities for growth and change. Overall, the questionnaire proved helpful in assessing the culture of diversity among professionals at the Midwestern children's hospital and identifying opportunities for awareness and inclusion.

The U.S. Census Bureau predicts that minority groups will comprise more than half of the population by 2044 (Colby & Ortman, 2015). Because of the changing ethnic and cultural landscape of the United States, there is a need to understand diversity in the workforce. Diversity itself is a difficult ideology to define; however, in the most basic sense, diversity is the differences of individuals based on positions within the society in which they live (Calasant, 1996). Diversity, according to De Meuse and Hostager (2001), "elicits a range of emotions, thoughts, and behaviors" that individuals bring to an organization (p. 47). Service delivery, like health care, also continues to adapt and change over time. Hospitals and the community environment are interconnected, and the more inclusive the environment, the better the two will work together and thrive (Ragins, et al).

Under the 2010 Affordable Care Act, patient and family satisfaction scores now greatly impact hospitals' financial support. This movement has resulted in increased attention toward cultural competence, defined as the awareness of one's own world view and the ability to positively interact with people across cultures, in the community and health care environ-

ment (Skaggs & Kmec, 2012). Whitman and Valpuesta (2010) found that the more diverse the workforce, the more likely staff are to understand multiple cultures, respond to differences, and provide quality care. Thus, it is important to identify supports and processes that assess cultural competence in the work environment (Pearson et al., 2007).

One way to assess an environment's cultural awareness is by conducting an equity audit. Equity audits, in the form of questionnaires, document reviews, and interviews, have become increasingly valuable to health care organizations. Some organizations use data from audits to aid in decision making on behalf of the healthcare environment and community (Weech-Maldonado et al., 2012). Matthews (1998) used a diversity audit to identify organizational problems, create strategic plans, compare practices, and to prioritize pluralistic initiatives. Because hospitals are complex organizations and melting-pots of the local environment, staff should be aware of diversity and practice competence when delivering care.

The purpose of this study was to conduct a pilot equity audit in a midwestern children's hospital's psychosocial department to assess the perceived culture

(behaviors, beliefs, and values) of diversity within the environment. The goal of the equity audit was to uncover ways in which the department could identify needs and strengthen awareness towards cultural competency. It is important to note that diversity and culture can be challenging to define due to varying contexts. For this study, the definition of culture, typically defined as the customs, arts, social institutions, and achievements of a nation, people, or social group, was left open to interpretation. However, the terms diversity, different groups, and range of backgrounds were defined to include diversity based on ethnicity, language, income, physical ability, mental ability, gender, and religion.

The current study outlines definitions of diversity and themes related to diversity in the workplace as synthesized from an extensive literature review. Themes include the physical environment, matching, communication, leadership, and education. The study describes the steps of completing an equity audit and concludes with results and application of information collected from the equity audit.

Literature Review

Researchers have expanded understanding of the impact of diversity in the workforce by assessing hospitals, organizations, human resources departments, individual workers, and communities. When defining diversity, previous researchers sought to consider diversity beyond the commonly-identified phenomena, race and gender, to also include psychosocial differences, generational differences, and social constructs. Weech-Maldonado and colleagues (2012) suggested the definition should also include health literacy, sexual orientation, and mental health. Groggins and Ryan (2013) considered diversity as any differences between people or groups and stated that the diversity climate includes perceptions of organizational characteristics and individual values. However, Marques (2010) preferred a unique holistic approach to defining diversity in stating “we are all members of the human species, thus not really significantly diverse” (p. 436).

Multiple research approaches and methods have been used in health care- and diversity-related research, but similar findings have emerged in relation to providing

optimal care and demonstrating cultural competence. Benefits to businesses that value cultural competence, uncovered by the research of Groggins and Ryan (2013), included sales growth, customer satisfaction, positive business outcomes, employee retention, community collaboration, improved communication, reduced ethnic disparities, and openness to change. Along with the many benefits, the findings, or themes, most often identified in research are related to the environment, diversity in the workforce (matching), communication, leadership, and educational training. The diversity-related themes laid a foundation for organizations to understand and respond to diversity so that partnerships could be made with the community and health care system. The following section provides an overview of common themes identified from a multitude of diversity-related studies.

Physical Environment

The physical environment of a hospital setting includes not only the building/campus, but also the social spaces, eating venues, sacred places, public areas, visual appearance, resources available, and attitudes of community acceptance. Lambert and colleagues (2013) agreed that the hospital environment can create positive experiences for patients, families, and staff, and can foster connectedness. In their study, children and families agreed that social spaces, like lounges and playrooms, which allowed leisure, entertainment, and connectivity, were most important in creating positive perceptions of an inclusive environment. Social spaces that included elements of integration, sharing, accessibility, socialization, resources, and diversity (ethnic, gender, ability, and interest) were most often identified when asked about feelings of belonging.

Research conducted by Linden and Nyberg (2009) focused on the impact of food consumption in the workplace as an identity marker, discussion topic, and non-verbal cue of ethnic diversity. Their research identified the lunch area as a melting pot for intercultural exchange, food preferences, traditions, and signs of gender, age, marital status, and ethnic origin. Participants in their study felt the lunch room was part of the community- and relationship-building process. Overall, the impact of food consumption in a public arena creates an important awareness for diversity.

Finally, spiritual or sacred places in health care settings are an important, yet sensitive part of the environment. Reimer-Kirkham and colleagues (2012) studied sacred places in health care and recommended that caregiving environments should contain spaces that nurture relationships, depict a variety of symbols, and accommodate multiple perspectives. Individuals in the study wished to continue practicing their spiritual beliefs throughout illness; therefore, a challenge was identified in creating a neutral space that was both culturally appropriate and welcoming to all visitors. Thanks to the research, it can be concluded that the physical environment contributes in many ways to diversity awareness in a pluralistic society.

Matching

One way that hospitals achieve cultural competence is through matching, which can be accomplished through recruiting a more diverse workforce. Matching, as described by Whitman and Valpuesta (2010), occurs when the “demographics of the workforce mirror that of the patient population” or community (p. 117). In their research, Skaggs and Kmec (2012) found that the larger the hospital and surrounding community, the more diverse the workforce. Matching in health care has a direct impact on employee desire to live in a specific community, patient compliance with treatment, and collaboration and communication among patients and care providers (Pearson et al., 2007; Polacek & Martinez, 2009; Ragins et al., 2012).

Having a patient-provider cultural match creates a stronger relationship by engendering trust, feelings of inclusion, and equal participation (Polacek & Martinez, 2009; Ragins et al., 2012). McGinnis and Moore (2009) stated that cultural competence develops within an environment that is welcoming to people of color and is one that provides equal opportunities and rewards. Involving minority community groups in the hospital design and services offered can result in a more diverse workforce that can increase the cultural competence and reduce disparities.

Communication

Culture and language determine how information is received, understood, and acted upon (Polacek & Martinez, 2009; Whitman & Valpuesta, 2010). Communication can be both a barrier and an avenue toward culturally competent care and satisfactory pa-

tient outcomes. There are many complex characteristics of communication mentioned in research that can jeopardize cultural sensitivity including nonverbal cues, volume, word choice, pronunciation, physical touch, written words, and the use of medical jargon (Polacek & Martinez, 2009; White & Chalmers, 2011). Patients and families identify a more positive satisfaction and greater well-being when clear, linguistically relevant, inclusive communication is used (White & Chalmers, 2011; Whitman & Valpuesta, 2010).

Another part of culturally competent communication is access to interpreters and resources in a variety of languages. Research has found that a strong determinant of positive patient experiences is related to on-site access to trained interpreters and having health information that is cognizant of cultural norms and written at an appropriate literacy level (Pearson et al., 2007). It is vital for hospitals to provide frequent evaluations of interpreter services for the safety of patients and to aid in overall communication. White and Chalmers (2011) identified that an easy way to increase effective communication is by documenting language preferences in the patients' medical records. Groggins and Ryan (2013) found that the more everyone was free to speak their language and openly celebrate their culture the more integrated the team.

Leadership

White and Chalmers (2011) emphasized the importance of recognizing the priority and value that leadership places on cultural and linguistic diversity. Leaders can have a great influence over the attitudes and climate of an environment that affect staff and consumers. It is vital for leaders to have system policies in place that can positively impact the level of culturally competent care (Pearson et al., 2007; Polacek & Martinez, 2009; Weech-Maldonado et al., 2012). Studies have found that management plays a key role in modeling cultural competence, and human resource departments can facilitate an ongoing commitment and ensure policy follow-through (Whitman & Valpuesta, 2010). Management that supports a diverse workforce, utilizes accommodation policies, and implements mentor programs encourage greater openness to peer differences (Groggins & Ryan, 2013). Finally, Weech-Maldonado and colleagues (2012) found that continual monitoring and outcome assessment is needed in order to keep pace with the ever-changing staff and patient population.

Education

Education is typically part of the process that leads to understanding and demonstrating skills in a new concept, and cultural competence is no exception. In fact, Pearson and colleagues (2007) and White and Chalmers (2011) agreed that diversity is so complex that training should be an ongoing process that starts with developing cultural competence at the undergraduate, postgraduate, and medical school level. Training interviewers to recognize bias is just as important as hiring someone who provides exceptional care (Lumb et al., 2010). Polacek and Martinez (2009) urged that cultural training also be assessed for bias and that the training itself be diverse and representative of the community environment. After extensive research, De Meuse and Hostager (2001) went so far as to say that frequent diversity training may be irrelevant if initial focus is placed on building a strong, caring workforce where similarities are celebrated. Having multiple opportunities for education and assessment can create awareness and initiate improvements toward an inclusive workforce climate.

Current Study

The purpose of this study was to conduct a pilot equity audit in a midwestern children's hospital's psychosocial department to assess the perceived culture (behaviors, beliefs, and values) of diversity within the environment. The audit included a variety of assessments related to the common themes found in research including environment, matching, communication, leadership, and education.

Methods

Research Setting

The study was conducted within a mid-sized children's hospital in the Midwest. The hospital includes 80 inpatient beds, an emergency department, outpatient specialty clinics, a surgical floor, and a radiology/diagnostic center. The hospital serves both rural and urban communities from surrounding states. The hospital was built in the year 2007 and operates under an overarching medical foundation. The hospital was designed with input from staff, a parent advisory board, and previous patients. Staff that work in the children's hospital are specifically trained in pediatrics. The mission statement of the hospital is to work together to be a national leader in health care, advancing the well-being of all people through

excellence, innovation, compassion, integrity, respect, and accountability. This study took place over a three-month period with a questionnaire being electronically available for four weeks.

Participants

Participants were restricted to a psychosocial department within the children's hospital that consisted of child life specialists, social workers, chaplains, administrative staff, and support staff. Of the 27 individuals invited, 17 voluntarily completed the questionnaire. All but one of the participants were female. All 17 participants were White, ranging in age from 27 to 59 years. The mean age of participants was 40 years old. One participant responded "middle age" and listed no chronological number. Participants most frequently reported having six to 10 years of service at the Midwestern children's hospital (six participants), while all participants ranged between fewer than six months to 21 to 25 years of service.

Questionnaire

An email invitation was sent to 27 staff with a description of the research, consent information, and SurveyMonkey link to the questionnaire. The questionnaire was available for a four-week time period during the spring of 2015. One reminder email was sent during the third week to encourage the participation of any other staff who had not already completed the questionnaire. A consent form was included in the email, and participants consented by clicking the SurveyMonkey link to begin the questionnaire.

An equity audit, in the form of a questionnaire, was adapted to fit the Midwestern children's hospital from research by De Meuse and Hostager (2001), Ginsberg (2004), Pearson and colleagues (2007), Weech-Maldonado and colleagues (2012), and Whitman & Valpuesta (2010). The questionnaire (see Appendix A) began with a short section to gather participant demographic information such as sex, age, race, ethnicity, and years of service. The questionnaire contained 21 Likert-style items that asked participants to rate each item according to their experiences within the hospital and department as strongly agree (1), neither agree nor disagree (2), or strongly disagree (3). The questions were divided into sections to more easily organize the data: environment and matching, communication, and leadership and diversity education. One open-ended reflection question asked participants to identify one or two of the previous hospital environ-

ment, matching, communication, leadership, or diversity education items that, from their perspective, were most important/critical to diversity within the hospital (see question #22 in Appendix A).

The questionnaire concluded with the Reaction-To-Diversity Inventory (RTDI) developed and validated by De Meuse and Hostager (2001). This tool was designed as a non-threatening assessment of attitudes and perceptions of workplace diversity. The tool was created as a generalized measure in order to create openness and individual interpretation to varying perspectives. The instrument includes 70 one-word items that are both positive and negative. The words are used to assess an optimistic, realist, or pessimistic outlook on a 5-dimensional framework of workforce diversity including categories of emotional reactions, judgments, behavioral reactions, personal consequences, and organizational outcomes. Participants in the current study were asked to check each word that they frequently associated with their present-day workplace diversity (see question #23 in Appendix A).

Data Analysis

Descriptive statistics and measures of central tendency were used to analyze the data. Standard deviations and frequency distributions of Likert scale items were computed. Standard deviations closer to 1.0 indicated that participants had varied opinions, and scores closer to 0 indicated that participants had similar opinions. Two incomplete surveys were eliminated, leaving 17 completed. The open-ended question was coded by categorizing responses based on the established diversity themes and by counting the number of times each theme was identified.

The RTDI was scored by giving each positive word a value of +1 and each negative word a value of -1. The total score was then added for a summary of participants' overall orientation to workplace diversity. Scores ranging from +35 to +11 were classified as optimists. Scores ranging from +10 to -10 were classified as realists. Scores ranging from -11 to -35 were classified as pessimists.

Results

Questionnaire

The data collected aimed to assess whether participants were in agreeance or had varied opinions about hospital diversity-related themes. Most of the par-

ticipant responses included some degree of varying opinion, indicated by a standard deviation of 0.70. The question in which participants most agreed was related to the role of leadership in-services and training. Of the 17 participants, 14 strongly agreed (82%) that the organization's leadership should encourage culturally and linguistically diverse services and training. Most participants (76%) also agreed that they felt comfortable discussing diversity issues within their department. Participants differed most regarding their perceptions of the adequacy of the hospital's interpreter services meeting the needs of patients and families. The question in which the greatest number of participants strongly disagreed (59%) was related to the hospital's special events.

Open-Ended Question

The open-ended question asking participants to share which of the diversity themes was most important/critical within the hospital was answered by 12 participants. Seven participants agreed that diversity education was most important by stating the desire for "educational classes," "cliff-notes version of different cultural beliefs and traditions," and "training." One participant felt that "yearly reviews or testing" would be helpful to "increase staff awareness." Six participants stated that communication was most important in relation to "interpreter services," "resources," "care provided," and "face-to-face interactions." The physical environment, such as a place "that supports and welcomes the diversity of all staff, visitors, and the community" was valued by three participants. Responses such as "leadership making it an everyday practice to provide staff with the information needed" revealed that two participants felt that leadership was most important. Finally, two participants noted that matching was critical in the hospital setting, with one participant mentioning "increasing opportunities for a more diverse patient/family population to be involved with patient education."

Diversity Inventory

The positive and negative words in the RTDI were organized into five categories: emotional reactions, judgments, behavioral reactions, personal consequences, and organizational outcomes. Overall, the 16 participants who completed the inventory were optimistic about workplace diversity, indicated by a mean score of +23. Out of the 35 positive words presented in the inventory, only two words were not chosen by any of the participants: merit and profitable.

The words, all positive, chosen most by participants included compassionate (12), ethical (10), listen (9), support (8), team-building (7), collaborate (7), and opportunity (7). “Behavioral reactions” was the highest scoring category for positive words with +47 score.

Out of the 35 negative words presented in the inventory, only 10 were chosen by the 16 participants. Participants chose most negative words from the personal consequences category, which included insecurity (3), pressure (1), rivalry (1), sacrifice (1), and stress (2). Other negative words chosen were categorized as emotional reactions: confused (4) and frustration (3); and organizational outcomes: bureaucratic (1), regulations (2), and turnover (3).

Discussion

The purpose of this study was to assess the perceived culture of diversity at a midwestern children’s hospital and to identify ways to strengthen awareness of diversity within this hospital. Results from the equity audit provided great insight into the culture of diversity within the Midwestern children’s hospital’s psychosocial department. Most importantly, participants appeared open to diversity in health care, which was demonstrated by their willingness to complete the questionnaire and by their openness to discussing diversity with others. Staff indicated being generally open to further learning and diversity education and reported a desire to learn more in order to provide better care and service. Overall, the study contributed to understanding the culture of diversity within a children’s hospital setting. Specifically, results showed that the culture of diversity appeared to be an optimistic one with many opportunities for growth and change. Groggins and Ryan (2013) suggested that a diversity assessment should be a continuous and ongoing process. The next five sections will look at the current study results as related to the diversity-related research themes.

Physical Environment

Several elements within an environment can affect perceptions of diversity. Elements in a hospital setting that could impact diversity include physical structure, social spaces, eating venues, religious places, public areas, visual appearance, resources available, and attitudes of community acceptance (Lambert et al., 2013; Linden & Nyberg, 2009; Reimer-Kirkham et al., 2012). The current study found that there were

differing opinions related to diversity within the environment. More participants agreed that the Midwestern hospital lacked diversity within family spaces, food offerings, and special events. It is important to be aware of the impacts of an environment on overall psychosocial well-being, especially those related to leisure, entertainment (like special events), and social connectivity (Lambert et al., 2013). One participant in the current study stated that “acknowledging events and holidays of other cultures would be important to diversity.” However, participants also felt that the hospital modeled diversity within the artwork, informational displays, and social media and was welcoming overall. All the elements together show that the hospital environment is more than physical space or care provided. As Reimer-Kirkham and colleagues (2012) emphasized, diversity in health care is about creating an experience.

Matching

Research has found that a diverse workforce leads to increased performance, innovation, cooperation, community involvement, and cultural competence (Ragins et al., 2012; Whitman & Valpuestra, 2010). A diverse workforce can often be achieved by matching the demographics of the workforce to the demographics of the community. In the current study, participants agreed that the Midwestern children’s hospital matched the diversity of the patient population. One participant stated, “I think this is challenging; 88.9% of people living in this midwestern state are Caucasian. I think the hospital staff is representative of that statistic.” Even though the match of the local workforce may be accurate, there is still a need for culturally competent care in order to avoid health disparities and to diversify the cultural climate (Polacek & Martinez, 2009).

Communication

In their study, White and Chalmers (2011) found that the process of communication within health care lends itself to the biggest challenges, the most complaints, and the greatest complexities. Whitman and Valpuestra (2010) also identified communication as the most important factor in health and well-being. The current study assessed different modes of communication for their promotion of diversity and equity and found diverging opinions. Varied responses were related to interpreter services, resources from diverse perspectives, care to support all backgrounds, and individualized patient education materials. One

participant indicated that the “hands-on or face-to-face interactions” were most important to diversity within the hospital, while another stated “interpreter services” were most critical. It can be concluded that improvements in communication equity need to occur for participants to feel confident and agreeable about services provided.

Previous and current research show that communication encompasses more than spoken or written language. However, communication can also result in the greatest cultural barriers (Polacek & Martinez, 2009). One positive derived from the current study was that none of the participants indicated that they did not feel free to discuss diversity issues within their department. The existence of openness and awareness of diversity leads to increasing acceptance and inclusion, which ultimately develops into respect (Groggins & Ryan, 2013). The fact that participants volunteered time to participate in the questionnaire also shows their openness and willingness to discuss diversity-related issues.

Leadership

Much of the previous research exploring diversity in the workforce and within health care found that diversity is greatly influenced by the leadership team. Leaders at all levels can make an impact on employee attitude, policy, the environment, level of care, growth, improvement, and follow-through (Reimer-Kirkham et al., 2012; Weech-Maldonado et al., 2012; Whitman & Valpuesta, 2010). The current study supported previous research finding that participants feel that it is within the role of leadership to recruit staff from diverse backgrounds, ensure the leadership team is diverse, advocate for social justice, and encourage culturally and linguistically diverse services. One participant stated, “Leadership is making it an everyday practice to provide staff with the information needed to provide a patient- and family-centered approach for ALL.” Another participant felt that leadership could increase “staff awareness of the varieties of diversity by education and/or yearly reviews with testing.” One of the greatest lessons learned from the current study is that participants overwhelmingly agree that leadership should be held responsible for diversity matters.

Education

Diverse services, according to Groggins and Ryan (2013), would include employee training and educa-

tion. When asked, participants in the current study most often indicated that diversity education was critical for supporting hospital diversity. Participants valued and desired “educational items and materials,” “educational classes,” “presentations,” “learning materials and strategies,” “training in working with diverse populations,” and “having more educational pamphlets, handouts, and resources.” However, participants were impartial on whether the Midwestern hospital trained support staff and medical personnel to identify and care for patients from different cultural backgrounds. It can be concluded that staff value training and education in order to work toward the most inclusive environment and that leadership can help in creating awareness and implementing positive policies. It is important to remember that because the concept of diversity is so complex, assessment, discussion, and training should be an ongoing process (Groggins & Ryan, 2013; Pearson et al., 2007; White & Chalmers, 2011).

According to the RTDI results, participants were optimistic about workplace diversity overall. It was interesting that the positive words most often chosen were from the behavioral reactions category, which reflects an individual’s planned verbal and nonverbal actions. Participants from the hospital’s psychosocial department have been trained in listening, supporting, and understanding, which could explain why words from the behavioral reactions category were so often chosen. It was also interesting that two positive words not chosen by any participants, “merit” and “profitable,” relate to money. Participants may have viewed these words more negatively or may not have placed a high value on money and, therefore, did not connect money to diversity. Finally, the negative words most often chosen were from the category of personal consequences. Personal consequences, such as “stress” and “insecurity,” relate to perceptions of how diversity might affect everyone (De Meuse & Hostager, 2001). Current participants’ negative feelings may have contributed to a lack of training or education related to diversity.

Conclusion

Limitations

Some limitations do exist within the current study. First, the sample was not representative of the workforce of the Midwestern children’s hospital; a more representative sample would include all departments

and staff within the hospital. Expanding the research to other disciplines, not just the psychosocial department that is likely to be more open to diversity in general, may provide different results and create a different picture of the culture of diversity. Second, there was one error made in utilizing the RTDI: The word “lashes” was used instead of the word “clashes,” and this error may have resulted in errant responses. Third, the data collected were descriptive in nature. Thus, the findings are limited by summations and cannot be generalized to the entire population. Finally, in the current study the definitions of the terms “diversity,” “different groups,” and “range of backgrounds” did not include sexual orientation or preference. Research done by Ragins and colleagues (2012) indicate that sexuality is also an important contributor to the diversity climate.

Implications

The current research has many implications for the Midwestern children’s hospital and the growing body of hospital diversity research. There are many benefits to understanding diversity and implementing strategies to create inclusive environments including diversity awareness, opportunities for staff to reflect on their own cultural assumptions, understanding organizational impacts, impacts of diversity on patients and families, and more positive staff attitudes and perceptions.

The current research indicated specific diversity-related items that are most important and valued by participants. This information can be used to implement new policies, improve education programs, and create overall diversity awareness. It was important to find that staff at the Midwestern hospital were optimistic and generally open to discussing diversity. Staff requests for increased education and training and the need for leadership involvement provide specific opportunities for future improvements. Sharing the data and participant responses will be important for leadership to gain understanding of the need for diversity services and cultural competence in the hospital and community setting. Recommending opportunities for training and diversity education will be the priority. These findings and suggested opportunities for improving cultural awareness will be presented at an in-service for any interested staff in order to promote further awareness and provide follow-up.

Future research might include providing diversity education and then offering the questionnaire in order to compare pre- and post-training data. The questionnaire might also be extended to hospital patients and families to assess whether their attitudes and perceptions of diversity match those of employees. Future studies could also focus on assessing policy and organizational change, such as the effect of employing additional interpreters, to examine challenges and changes in the diversity culture.

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Appendix A

Demographics

Please indicate the sex for which you identify.	Male, Female, Other
What is your race/ethnicity?	Fill in the Blank
What is your age?	Fill in the Blank
How long have you been employed at this hospital?	Scale starting at < 6 months and ending at >40 years

A Questionnaire for Evaluating Hospital Diversity

This questionnaire provides an overview of issues that are found in the literature on diversity and hospitals. Briefly consider each item according to your experiences within your hospital and department and rate as **strongly agree (1)**, **neither agree nor disagree (2)**, or **strongly disagree (3)**.

Throughout the questionnaire the terms diversity, different groups, and range of backgrounds includes diversity based on **ethnicity**, **language**, **income**, **physical ability**, **mental ability**, **gender**, and **religion**. The statement “staff and visitors” includes all hospital employees (medical and support), guests, patients, and families.

This questionnaire was adapted from the work of Ginsberg (2004), Weech-Maldonado et al. (2012), Whitman & Valpuesta (2010), and Pearson et al. (2007).

ENVIRONMENT AND MATCHING

1. Patient/family spaces include books, magazines, videos, music, etc. about people from a range of backgrounds.	1	2	3
2. The artwork around the hospital depicts members of different groups of people.	1	2	3
3. The hospital accommodates the ethnic/cultural dietary preferences of staff and visitors.	1	2	3
4. Special events reflect the ethnic and cultural diversity of staff and visitors.	1	2	3
5. Bulletin boards, social media, and other displays reflect diversity within the hospital.	1	2	3
6. The hospital creates an environment that supports and welcomes the diversity of all staff, visitors, and the community.	1	2	3
7. Community representatives routinely involved in the planning and design of the hospital and its services for diverse populations.	1	2	3
8. The hospital staff matches the diversity of the patients and families served.	1	2	3

COMMUNICATION

9. The interpreter services adequately meets the needs of patients and families.	1	2	3
10. Resources/publications are written from the perspective of diverse groups of people.	1	2	3
11. Care provided supports values, attitudes, and behaviors of people from diverse backgrounds.	1	2	3
12. There are a variety of methods used to ensure that all patients/families who speak a language other than English have adequate support for communication.	1	2	3
13. The hospital tailors patient education materials to different cultural and language groups and all types of learners.	1	2	3
14. I feel free to discuss diversity issues within my department.	1	2	3

LEADERSHIP AND DIVERSITY EDUCATION

15. The hospital recruits and retains staff members and students from diverse backgrounds.	1	2	3
16. There (or has there been) persons from diverse racial/ethnic backgrounds in leadership positions.	1	2	3
17. In the hospital, support personnel AND medical personnel are trained to identify and care for patients from different cultural backgrounds and who speak different languages.	1	2	3
18. Staff, including leaders, are encouraged to advocate for social justice.	1	2	3
19. I feel the annual employee satisfaction survey measures the diversity climate.	1	2	3
20. Culturally and linguistically diverse services and training should be encouraged by the organization's leadership.	1	2	3
21. The hospital has formal and ongoing training programs on cultural diversity.	1	2	3

22. Please identify one or two of the previous hospital environment, matching, communication, leadership, or diversity education items that, from your perspective, are most important/critical to diversity within the hospital.

Created and validated by De Meuse and Hostager (2001)

23. Check all the words below that you frequently associate with your current workplace diversity.

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