EXECUTIVE SUMMARY

A Racial/Ethnic Comparison of Career Attainments in Healthcare Management

Background

A 1992 joint study by the American College of Healthcare Executives (ACHE), an international professional society of healthcare executives and the National Association of Health Services Executives (NAHSE), whose membership is predominantly black, compared the career attainments of their members. Follow-up studies were conducted in 1997, 2002 and 2008. The study groups were broadened to include Hispanic and Asian healthcare executives. Sponsorship was correspondingly enlarged to include the Institute for Diversity in Health Management (IFD), the National Forum for Latino Healthcare Executives (NFLHE) and the Asian Health Care Leaders Association (AHCLA). The central objective of this fifth cross-sectional study is to determine if the racial/ethnic disparities in healthcare management careers have narrowed.

In looking at the evidence from the current survey, the reader is cautioned that the results from this study, like those conducted previously, are not intended to represent the state of the healthcare field. Respondents to the study are members of the American College of Healthcare Executives, the National Association of Health Service Executives, the National Forum for Latino Healthcare Executives and the Asian Health Care Leaders Association and therefore are not a random, representative sample of all healthcare executives. However, comparisons between members of the different racial/ethnic groups within the 2014 study, and comparisons with the sample of respondents from the 2008 study, hold valuable information for healthcare leaders who are looking to create truly diverse organizations.

Methods

In 2014 a survey questionnaire consisting mainly of items from the previous years' questionnaires was administered to black, white, Asian and Hispanic executives currently employed in healthcare. The sample of white healthcare executives, containing equal numbers of men and women, was drawn from among ACHE Members and Fellows. Black executives were sampled from ACHE and NAHSE membership databases. The survey was also administered to all currently employed Hispanic and Asian Members and Fellows of ACHE; and to Hispanic members of NFLHE and Asian members of AHCLA contained in member lists supplied by those organizations.

The breakdown of responses and response rates to the survey is shown in Table 1 and was as follows: black executives—484 or 30.8 percent; white executives—420 or 30.0 percent; Hispanic executives—299 or 30.3 percent; and Asian executives—318 or 28.4 percent. Aggregating all these groups, the survey was sent to a total of 5,078 individuals. By the end of the study, 1,521 responses were received, of which 1,409 were useable. The overall response rate was 30.0 percent. These response rates were lower than achieved in 2008, when the overall response rate

was 37.4 percent. While the cause of these decreases in response rates are unclear, this is consistent with generally declining response rates in surveys over time.

To control for the effects of gender, findings are reported separately for women and men in each of the racial/ethnic groups. In this summary, results for the gender groups are aggregated when their differences were unimportant. A non-response analysis based on ACHE data (included in Appendix A) showed respondents were not significantly different from non-respondents in their field of highest degree. However, black and Hispanic respondents tended to be a little older than non-respondents in those racial/ethnic groups; black, white and Hispanic respondents were more likely to hold an advanced degree than non-respondents in those groups, and white respondents were more likely to work in hospitals than white non-respondents. (Statistical tests suggested that Asian respondents are somewhat more likely to occupy senior positions than Asian non-respondents; however, the numbers involved are small enough that this result should be interpreted with caution.)

Major Findings

Data from this study are presented in a series of tables at the end of this document. The following is a summary of major findings from the 2014 survey.

Section 1: Demographic Comparisons

Table 2 presents the general table configuration for all the data in the study. Each table is divided into male and female responses. This allows us to control for the effects of gender on career attainments and focus only on race/ethnicity. When the effects of gender are not material, we cite the statistics for the two groups combined, listed under "All." Statistical tests for the comparison groups are made by gender and for both combined. Finally, important differences between the results observed in 2014 with prior studies, notably 2008, are indicated in the text.

By design, approximately half of the 1,409 respondents were male. White respondents as a group were the oldest (median age 52 years) and Asian respondents were the youngest (median age 41 years). About three-quarters or more of respondents were married, and women were less likely to be married or partnered than men. This was particularly notable among black and white participants where 16 and 13 percent more men than women, respectively, reported being married or with partners. Black, white and Hispanic respondents had a median of 2 children; the median was 1 among Asian respondents. Men were more likely to have three or more children than women. Three quarters or more of the study respondents held graduate degrees, and between 10 and 20 percent held doctorates or professional degrees.

Section 2: Career Outcomes

Current position. More white men achieved CEO positions than other men in the study (Table 3). The difference is possibly, in part, due to the fact that minority men had attained fewer years of healthcare management experience than white men (Table 16). While a higher proportion of white women held the CEO role than minority women, the differences were not as marked as among men.

When we consider all senior executive positions (adding CEO and chief operating officer/senior vice president together) the proportion of white men in those roles (51 percent) continues to exceed that of minority men (proportions ranging from 26 percent among Asian men to 44 percent among Hispanic men). Within each racial/ethnic group, smaller proportions of women than men hold these senior positions (proportions of women who are senior executives ranging from 19 percent among black women to 32 percent among white women).

Area of responsibility. Between half and two-thirds of men and women healthcare executives held general management roles at the time of the study (Table 4). Between 9 and 19 percent of all respondents reported occupying a position in a single business discipline (e.g., finance or human resources) and between 8 and 18 percent said they occupied a clinical or clinical support position.

Employing organization. Hospitals were the largest employers of respondents to the study (Table 5). Roughly half of all men and women who answered the questionnaire were employed in health system hospitals or in system headquarters. White and Hispanic men (roughly one-quarter) were somewhat more likely to be employed by freestanding hospitals than were Asian or black men. Among women, white women were somewhat more likely to be employed in freestanding hospitals than women in racial/ethnic minorities. Black and Asian men were more likely to work in larger hospitals than white or Hispanic men. Among women, variation in the size of organizations in which they worked was less pronounced.

Not-for-profit secular organizations were also the largest employers of respondents to the study, employing between a third and a half of executives who answered the questionnaire. About 80 percent of white respondents said they worked in hospitals where the majority of employees were white, as did roughly half of respondents in racial/ethnic minorities. Similarly, those respondents working for organizations where the majority of employees were non-white were most likely to be members of that majority.

Organizational culture. The most widespread diversity program in place in survey respondents' organizations was social gatherings for employees, present in roughly two-thirds or more of respondents' workplaces (Table 6). A little more than half of the study respondents reported that their organizations had affirmative action programs. Roughly half of organizations reportedly had mentoring programs, conducted diversity trainings for managers every three years or had a policy of seeking diversity candidates for hire. The existence of a diversity committee, having a manager responsible for diversity or a strategic or business objective to increase diversity was reported by just under half of all respondents as a group; and in the neighborhood of one-third of respondents said their organizations supported affinity groups or had a plan to increase the number of ethnically, culturally and racially diverse executives on the senior leadership teams. The least commonly-reported diversity programs were diversity incentives for managers. Roughly one-fifth of all respondents said that managers in their organizations were evaluated with respect to diversity and only about 10 percent said that a portion of executive compensation was tied to diversity goals. Fewer than 15 percent of respondents in all race/ethnicity groups reported that their organizations rewarded fluency in Spanish.

When asked for their appraisals of their organizations' cultures with respect to diversity, black respondents in general gave the lowest ratings and white respondents were most satisfied with the current state where they work. In particular, 83 percent of white respondents, 76 percent of Asian and Hispanic executives, but only 53 percent of black executives agreed with the statement "race relations in my organization are good." Black respondents were slightly less likely to say that relations between white and minority managers, and between members of different minorities, could be better where they worked than in the 2008 study. Respondents in all race/ethnicity groups said that they rarely attended informal, non-work social gatherings with managers of different race/ethnicities. The more prevalent of these activities were informal lunches, attended by a little less than one-third of all respondents.

The relationships between diversity programs and perceptions of black, Hispanic and Asian respondents that race relations in their organizations were good are shown in Figures 1, 2 and 3, respectively. Black, Hispanic and Asian executives were all more likely to report that race relations in their workplaces were good if their organizations offered social gatherings for employees. Both black and Asian executives were more likely to feel that race relations were good in organizations where diversity was sought in candidates for hire and within the senior leadership team, and Hispanic and Asian respondents were more likely to feel that race relations were good in organizations offering mentoring programs. Hispanic executives were more likely to feel good about race relations in their organizations if they offered diversity evaluations for managers. Black executives were also more likely to feel good about race relations in their organizations if the following were present: affirmative action programs, diversity committees, a manager responsible for diversity, diversity training for managers at least every three years, affinity groups, a strategic or business objective to increase diversity and inclusion, and rewards for fluency in the Spanish language. The only diversity program that was not associated with a significant increase in positive feelings about organizational race relations among executives in any racial/ethnic minority group was tying a portion of executive compensation to diversity goals.

Compensation. In calendar year 2013, white males in the study earned a median of $190,000 (Table 7). Hispanic males earned 17 percent less than white males (a median of $142,500) and black and Asian men earned 25 percent less (a median of $142,500). The salaries of Hispanic, Asian and black men are closer to those of white men in the 2014 study than in the 2008 study, when they differed by 21 percent, 34 percent and 30 percent, respectively. White women also earned 25 percent less than white men (also a median of $142,500). Asian women earned 11 percent less than white women (a median of $127, 500) and black and Hispanic women both earned 21 percent less than white women (a median of $112,500). This represents a smaller salary gap between white and Asian women than was found in the 2008 study. The reader is cautioned that these median salaries do not represent the healthcare field as a whole.

Controlling for education and experience (Table 9), white men earned a median salary of $184,444 in 2013. Black men earned 17 percent less (a median of $153,004) while Hispanic men earned 8 percent less (a median of $169,829). This represents a narrowing of the salary gap between Hispanic and white men since the 2008 study, when it was 14 percent. In 2008 Asian men earned 22 percent less than white men; in the current study this gap has not only closed but reversed, with Asian men making about 4 percent more than their white counterparts (a median

of $191,161). Readers should interpret these results with some caution, as the analysis is approximate and the sample sizes involved are small.

Again controlling for age and experience, in 2013 white women earned a median salary of $141,563, or 23 percent less than white men. Black women earned 13 percent less than white women (a corrected median of $123,121), which represents a greater disparity between compensation for black and white women than was found in 2008, when their median salaries were roughly equal. The gap between salaries for white versus Hispanic and Asian women, which was 10 percent and 11 percent (respectively) in 2008, has disappeared in 2014 and women in these minority groups make a little less than 1 percent more than white women.

Job satisfaction. More than three-quarters of study respondents said they were satisfied or very satisfied with their current position (Table 10). Black respondents as a group were less satisfied with certain aspects of their position such as the degree of respect and fair treatment from those who supervise them, the treatment and sanctions they receive when they make mistakes, and the pay and fringe benefits they receive for their contributions for their organizations.

Identification with job. Most respondents expressed high or very high levels of identification with their employers (Table 11). About 95 percent or more of respondents from all racial/ethnic groups agreed with the statement "When I talk about my organization, I usually say 'we' instead of 'they'." Racial/ethnic differences do appear in other measures of organizational affinity, and black respondents were less connected than other racial/ethnic groups with their organization by these measures.

Section 3: Accounting for Different Career Outcomes

Education. All study respondents had completed college (Table 12). Respondents in general were most likely to have majored in general business during their undergraduate training (ranging from 17 percent of Asian respondents to 26 percent of Hispanic respondents), although Asian respondents were most likely to have majored in the biological sciences. Perhaps due to their older median age, white respondents had held their degrees for a longer time than members of other racial/ethnic groups.

Over 90 percent of those in the study had completed graduate degrees (Table 13). About half had taken graduate degrees in health administration, and between one-quarter and one-third had studied business administration. As with undergraduate degrees, white respondents had held their graduate degrees for a longer time than members of other racial/ethnic groups at the time of the study.

In general, a higher proportion of black and Asian respondents participated in internships and fellowships than white or Hispanic respondents (Table 14). A little more than one-third of black and Asian respondents reported completing internships and 17 percent said they completed fellowships. This is in contrast to about one-quarter of white and Hispanic respondents completing internships and one-tenth completing fellowships. Overall, about 20 percent of respondents completed healthcare management residencies. More than half of those who participated in residency programs, and roughly three-quarters of those who completed fellowships, were hired by the organizations where they participated in those programs.

Roughly three-quarters of all respondents stated that they had a mentor in healthcare management. White men were most often identified as mentors by all men regardless of race/ethnicity. White, black and Asian women were almost equally likely to identify a white man or woman as a mentor, although Hispanic women were about one-and-a-half times more likely to name a white woman than a white man as a mentor. About half of black respondents mentioned having black mentors; the proportion of Hispanic or Asian respondents identifying members of their own racial/ethnic groups as mentors was much lower.

Career origins. Department head was the most common level where most study respondents began their healthcare management careers, following by department staff (Table 15). Men were somewhat more likely than women to begin their careers at the vice president level or above. The most common area in which to start management careers for most respondents was general management, although white women were more likely to begin with a position in clinical management or management of clinical support areas. Overall, more than 65 percent of respondents began their careers in hospitals. Significantly more white respondents began their careers in freestanding hospitals (42 percent) than did persons in other race/ethnicity groups. All respondents were most likely to have taken their first healthcare management job in a not for profit secular organization. Over 70 percent of all respondents chose their first firm with the intention of building their careers in those organizations.

Career experience. White respondents to the study had accrued the most healthcare management experience with a median of 19.0 years (Table 16). Asian respondents had the lowest median number of years of healthcare management experience with 9.1, and black and Hispanic respondents fell in between with median years of healthcare management experience of 13.5 and 12.5 years, respectively. Approximately two-thirds of respondents were no longer in the same organization where they started their healthcare careers. Between half and three-quarters of respondents said they have served as a mentor to someone in the healthcare field.

Career history. About 30 percent of all respondents said they had taken less desirable positions during their careers to respond to family demands (Table 17). In general, black (29 percent) and Hispanic (26 percent) respondents were more likely than others to say they had taken a less desirable position due to financial needs; and black and Hispanic respondents (38 percent and 36 percent, respectively) were more likely than white respondents (24 percent) to say they had taken a less than desirable position because of lack of opportunity. Very few – about 5 percent or less of the members of each racial/ethnic group – took a less desirable position because they lacked education. Eleven percent or fewer of all respondents said they had interrupted their careers for either family demands, financial need, lack of opportunity or lack of education.

Black healthcare executives reported adverse events occurring during the last five years of their careers due to racial/ethnic discrimination to a greater extent than the other racial/ethnic groups; white respondents reported such experiences the least. Overall, respondents were generally satisfied with the extent to which their education adequately prepared them for the challenges of their first healthcare management positions and their ability to balance their work and personal lives. However, black respondents were most likely to say they were negatively affected by racial/ethnic discrimination in their careers and to have witnessed a fellow worker's healthcare

management career to be affected by such discrimination. White respondents were the least likely to report either of these; Hispanic and Asian respondents fell between these two extremes. Black respondents were less likely than members of other racial/ethnic groups to say they were satisfied with their current progress toward their career goals.

The highest proportion of male respondents across all racial/ethnic groups identified their first position in their current firm as department head (ranging from 26 percent among white men to 38 percent among Hispanic men) (Table 18). However, almost one-quarter of white men reported that their first position in their current firm was at the CEO level; by contrast this was true of only 17 percent of Hispanic men, 16 percent of black men and 7 percent of Asian men. Women were also most likely to have begun in their current organization at the department head level (ranging from 36 percent among Hispanic women to 43 percent among white women). Unlike men, however, the second most common position women first took in their current firm was department staff (ranging from 17 percent among white women to 28 percent among black and Asian women).

White respondents had been at their current firm for a longer period of time at the time of the survey (median tenure was 6.3 years) than members of the other racial/ethnic groups (within which the median tenures were 5.0 years, 4.2 years and 4.0 years for black, Hispanic and Asian respondents, respectively). Median tenure in their current positions within their current firms ranged between two and three years for members of the different race/ethnicity groups.

At the time of the survey, most senior executives said they were in the same positions in their current firms as when they first joined those organizations (Table 19). However, 36 percent of white respondents who began as department heads had taken on more senior roles, as opposed to 25 percent of Hispanic respondents, 22 percent of black respondents and 19 percent of Asian respondents. It is important to note that, as reported above, white respondents as a group reported longer tenures in their current firms than members of other racial/ethnic minorities.

Career expectations. Black respondents were the most likely to say they are planning to leave their current organization in the coming year (26 percent); Hispanic respondents were the least (17 percent) (Table 20). Five years from now, about 70 percent of black, white and Hispanic males, and 80 percent of Asian males, expect to be working in a hospital or system. These are similar to the proportions of men who reported working in these settings in 2014. About two-thirds of black and Asian women, and closer to three-quarters of white and Hispanic women, also expected to be working in a hospital or health system in 5 years, and these are also similar to the proportions of women in the study working in these settings in 2014.

As in prior research, we asked respondents whether or not they aspired to become a CEO in five, ten and fifteen years. (The data presented include those who were CEOs at the time of the survey.) White men were more likely than minority men to expect to be CEOs in the next five years. Almost half, 42 percent, of white men were looking to occupy the CEO position within the next five years, as opposed to 32 percent of black men, 31 percent of Hispanic men and 20 percent of Asian men. Equal proportions of black, white and Hispanic men (48 percent) and a lower proportion (30 percent) of Asian men expect to become CEOs in 10 years, and in fifteen

years over half of the men in the study expect to occupy CEO positions (55 percent of white and Asian men, 67 percent of black men and 69 percent of Hispanic men).

Across the board, smaller proportions of women saw themselves occupying CEO positions than men in the study. Between 14 and 22 percent of women in all racial/ethnic groups expected to be CEOs in 5 years, and between 22 and 31 percent of all women in the study expected to obtain this position within 10 years. Within 15 years between 37 and 47 women among all of the race/ethnicity groups expect to occupy this top leadership role.

Over 90 percent of respondents to the study said they were members of ACHE (Table 21). About 40 percent of black respondents were members of NAHSE, 17 percent of Hispanic respondents were members of NFLHE, and 14 percent of Asian respondents were members of AHCLA. Overall, a majority of executives in all racial/ethnic groups had participated in a professional society event in the recent past.

Section 4: Recommended Best Practices

Respondents were asked to list best practices that have promoted diversity in healthcare management (see Table 22). Prevalent among those suggestions were: having strategic initiatives, business initiatives or goals to increase diversity and monitoring company performance relative to those goals; creating an executive position with responsibility for diversity or creating a diversity department or committee; ensuring diversity in hiring; ensuring diverse representation on boards and among leadership teams; ensuring succession planning and having a commitment to develop and promote staff from within; conducting diversity trainings; evaluating managers on their attainment of diversity goals and tying a portion of executive compensation to meeting those objectives; creating mentoring programs; having affinity groups and having diversity events.

Conclusions

The bottom line question is, "According to the 2014 study, have we made progress in reducing the disparities observed in previous studies concerning the career attainments of racial/ethnic minorities in healthcare management?" In looking at the evidence from the 2014 study, the reader is reminded that the results from this survey, like those conducted previously, are not intended to represent the state of the healthcare field because the participants are not a random, representative sample of all healthcare executives. However, comparisons between members of the different racial/ethnic groups within the 2014 study, and comparisons with the sample of respondents in the 2008 study, hold valuable information for healthcare leaders who are looking to create inclusive organizations.

The positive news from the 2014 study is that:

1. When results are controlled for differing education and experience, the gap in median salary between white and Hispanic or Asian respondents is either much smaller than in 2008 or, in some cases, no longer exists.

2. The proportion of minority men in CEO positions is closer to that of white men in the 2014 study than in the 2008 study. While the ratio of proportions of Hispanic men to white men in CEO positions (78 percent) has remained relatively stable between the two studies, the ratio of proportions of black men to white men in CEO positions in the 2014 study was 62 percent; an increase from the 47 percent among respondents to the 2008 survey. Similarly, the ratio of proportions of Asian men to white men in CEO positions increased from 15 percent in the 2008 study to 28 percent in 2014.

3. The proportions of black men who said the quality of relationships between minority and white managers could be improved in their organizations, and who felt that the quality of relationships between minorities from different racial/ethnic groups could be improved in their workplace, were each lower in the 2014 survey than in the 2008 survey (by 10 percent and 9 percent, respectively).

Some disparities were more evident among respondents to the 2014 study than among those who participated in the 2008 study, namely:

1. In 2008 we reported that the proportion of minority women, particularly Asian and Hispanic women, in CEO positions was closer to that of white women than in 2002. In 2014 the gap has again widened between the proportions of white and minority female respondents occupying the CEO role. The ratio of proportions of black female respondents to white female respondents in CEO positions was 77 percent in 2008; it dropped to 57 percent in 2014. Similarly, the ratio between proportions of Hispanic and white women in CEO positions was 92 percent in 2008, but in 2014 this went down to 78 percent. The ratio of proportions of Asian and white women in CEO positions (78 percent) has remained fairly stable between the two studies.

2. The difference in median compensation between black and white women, controlling for education and experience, is greater in the 2014 study than it was in the 2008 study. The difference was less than a percent in 2008; in the 2014 study it was 13 percent.

Finally, there was little change in some key areas from 2008, namely:

1. Median salary for black men in 2014 was still less than that for white men, controlling for education and years of experience, by 17 percent. Also controlling for education and experience differences, there remains a gap between median salaries for men and women ranging from 16 percent among Hispanic respondents to 25 percent among Asian respondents.

2. In 2014 there continues to be disparity between white and minority respondents with respect to the amount of discrimination they report having experienced. For example, 29 percent of black respondents, 13 percent of Hispanic respondents and 16 percent of Asian respondents felt they were not hired for a position in the last five years because of their race/ethnicity, as opposed to 2 percent of white respondents. Similarly, 41 percent of black respondents, 20 percent of Hispanic respondents and 19 percent of Asian respondents reported they had failed to receive fair compensation in the last five years because of their race/ethnicity; this was only reported by 5 percent of white respondents. Looking more broadly at their working life, 48 percent of black respondents, 27 percent of Hispanic respondents and 26 percent of Asian respondents reported they had been negatively affected by racial/ethnic discrimination in their careers as opposed to 10 percent of white respondents. These are very similar to the findings in 2008.

3. Both the 2008 and 2014 studies looked at the prevalence of the following diversity programs in organizations: affirmative action plans, diversity committees, a manager responsible for diversity, diversity training for managers at least every three years, diversity evaluations for managers, social gatherings for employees and mentoring programs. There has been little change in the prevalence of these programs in healthcare organizations since 2008, as reported by respondents. While more than half of the organizations described in the study had affirmative action plans and social gatherings for employees in place, roughly half or fewer of respondents said the rest of these programs existed where then worked.

4. One of the recommendations from the 2008 study was that organizations continue to offer residencies and fellowships in healthcare management. Since the majority of respondents who serve as residents and fellows are hired by the organizations employing them in this capacity, they offer a way for healthcare managers to get a start on their careers. There has been little change in the past six years in the proportion of survey respondents who say they have completed a residency or fellowship; still in 2014 a minority of respondents (one-quarter or fewer) reported participating in one of these programs.

Recommendations

The following are a list of recommendations based on the study findings.

Equal pay for equal work: Even when we control for level of education and number of years of experience, white men in the study continue to earn significantly higher salaries than black and Hispanic men and all women. While not definitive because the specific circumstances of each executive in the study were not examined, the compensation results suggest that pay is not yet equitable in the healthcare management field. It is imperative that pay be based on the qualifications and responsibilities of the employed executive and in no way reflect biases relative to his/her gender or race/ethnicity**.**

Mentors: Mentors are prevalent among the respondents to the survey. This includes individuals beginning their careers and also mid-level and even senior-level executives who seek feedback and opportunities for professional development. Those executives who take the time and energy to offer advice and model ideal behaviors to others are clearly having a strong, positive impact on the field. Yet only roughly half of respondents report that mentoring programs are in place in their organizations. Given the importance of mentoring in our field, organizations should consider instituting formal mentoring programs as well as promoting informal mentoring relationships.

Diversity programs: The study clearly showed that the presence of certain diversity programs were related to minority executives feeling more positive about race relations in their workplaces. Social gatherings for staff were associated with a more positive outlook on race relations at work for respondents in all racial/ethnic minority groups studied. Other programs that were associated with more positive opinions of the state of race relations in workplaces among members of more than one racial/ethnic minority group included policies for seeking diverse candidates for hire, plans for increasing the diversity of the senior leadership team and mentoring programs (please also see the discussion about mentors above). Black respondents also felt more positively about race relations in organizations with affirmative action plans, diversity committees, a manager responsible for diversity, diversity training for managers at least every three years, affinity groups, strategic or business objectives to increase organizational diversity and inclusion and rewards for fluency in Spanish.

The study also showed that those diversity programs associated with more minority executives having positive feelings about race relations in the workplace were not universal in healthcare organizations. Social gatherings for employees, which were related to better overall feelings about workplace race relations among executives in all racial/ethnic minority groups, are present in about three-quarters of healthcare organizations as reported by respondents. Mentoring programs and a policy of seeking diversity in candidates for hire were reported by about half of respondents as being present in their organizations. Yet, these programs were associated with more positive feelings about race relations for members of at least two of the three racial/ethnic minority groups. Similarly, although larger proportions of both black and Asian respondents reported good feelings about workplace race relations in organizations where there is a plan to increase the diversity of the senior leadership team, these plans were reported as being in place in only about a third of all organizations where study respondents worked. Higher proportions of black respondents reported that race relations in their organizations were good in workplaces had

a number of other diversity programs, yet the prevalence of these programs ranged from about two-thirds for affirmative action plans to roughly one-fifth for diversity evaluations for managers.

At this time, it is unlikely that a truly diverse organization will develop without significant support from leaders and accountability at all levels. Healthcare organizations need to look carefully at the diversity of staff in all positions and whether it reflects the communities they serve, the inclusiveness of their hiring and promotion practices and the relations among employees and managers of different racial/ethnic groups and put in place programs to create a truly inclusive workforce. In addition, priorities and practices need to be clearly communicated to staff. This study reports executives' understanding of diversity programs in their organization; some may be unaware of their organization's initiatives in this area.

Residency and Fellowship: Based on the survey findings, it appears that more than half of those who participated in a residency eventually were hired by that organization. Even higher proportions of those who took fellowships were subsequently hired there. Residency and fellowship programs have benefits for the organizations that offer them; leaders get the opportunity to work with a new executive before making a permanent hiring decision about him or her. Therefore, healthcare organizations need to consider offering residency and fellowship opportunities to qualified graduates to assist their launch into careers in healthcare management.