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Importance of Cultural Competency Among the Leadership Teams

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Abstract

There is a multitude of cultural diversity issues facing all stakeholders in an organization especially the executive leadership team and management. As the workforce becomes more diverse, organizations are faced with managing cultural differences that go beyond race or color to include sexual orientation, age, disability, and language barriers. Thus, the integration of cultural competence in healthcare organizations is imperative. While policy and procedures are being developed and implemented, the range of leadership and employee perspectives can create opposition and subsequent disputes for the organization. The goal of this study is to identify the qualities upper management seek in the leadership teams and the barriers that exist among all employees. A systemic review of articles published between 1995 and 2022 was conducted. The findings demonstrate that interventions to improve cultural competence in organizations can improve organizational outcomes and employee satisfaction.

Keywords: Cultural Competence; Employee Satisfaction; Healthcare Workforce; Leadership Diversity;

1 Introduction

Cross-cultural leadership in healthcare organizations is important given the multitude of cultural and diversity issues facing all stakeholders especially the leadership team and management. As workforces become more diverse, organizations are faced with managing cultural differences that go beyond race or color. The range of challenges for management include differences associated with religion, sexual orientation, age, disability, and language barriers. While policy and procedures are being developed and implemented, the range of employees' perspectives can create opposition and subsequent disputes for the organization. These challenges can foster dissension within the organization and influence profitability. Woodrow Wilson said, "The ear of the leader must ring with the voices of the people" and therein lies the challenge (Power Quotations, 2023). As healthcare leaders focus on meeting the needs of both the workforce and patients these voices echo conflicting messages. How do we meet diverse needs of all stakeholders? What skills are needed by the leadership team? Will diversity among leadership change the perception of the workforce?

Cultural differences between leadership, patients, providers, and staff are key to quality care. Of note, cultural differences between the patient and their provider have shown to contribute to poor health outcomes through misunderstanding, value conflicts, and disparate concepts of health and illness (Lie, Carter-Pokras, Braun & Coleman, 2012). Healthcare organizations compete for patients and these patents seek information about both hospitals and providers. Therefore, healthcare leadership teams and providers must work across cultures to gain perspective, collaborate, and develop policies that engage all stakeholders. According to Weech-Maldonado, et al. (2012), there is evidence in the inpatient setting that minority patients report better experiences of care healthcare facilities that implement and strongly support cultural competency policies and practices. The purpose of this research is to examine the influence of cultural competence among leadership teams and the workforce with a focus on patient care in the healthcare arena.

2 Methods

A systematic literature search was undertaken of the following databases: Ebsco, Embase, Google Scholar, JSTOR, ProQuest, and PubMed. All papers reviewed were from 1995 to 2022. The literature review discusses cross-cultural leadership, diversity, healthcare organizations, culturally competent healthcare, challenges promoting diversity, impact on quality outcomes and identifies gaps in research.

3 Literature Review

3.1 Cross Cultural Leadership

In 1932, Elton Mayo's research led to findings that to motivate employees to greater productivity, human factors were more important than the physical environment. This body of work is referred to as the Hawthorne Studies. Research completed by other scholars extended the concept of group dynamics to an organization's outcomes framework, to gain commitment among stakeholders. One could consider Kurt Lewin's findings that the application of behavioral science knowledge to different levels of groups in an organization could be utilized to initiate planned change (Hussain, et al., 2018)

Maslow's Hierarchy of Needs is the most familiar theory among management and leaders. Maslow's framework for gaining employee commitment was a precursor to the works of Peter Drucker, Frederick Herzberg, and Douglas McGregor. Each theory offers insight for leaders on principles that motivate employers and influence the implementation of personnel procedures.

Human competence is not a new topic in management. Tom Gilbert published Human Competence: Engineering Worthy Performance in 1978 demonstrating that effective solutions must address both an individual's behavior and accomplishments, the factor of performance. In addition, Peter Senge's The Fifth Discipline: The Art and Practice of the Learning Organization discusses the theory that organizations have the capacity to shape their own future. Senge noted five disciplines that were required throughout the organization: System Thinking, Personal Mastery, Mental Models, Shared Vision and Team Learning. These are key components if healthcare organizations are desirous of achieving excellence in organization wide cultural competence (Senge, 2006).

Over time, researchers moved away from the scientific management theories and focused on the types of leadership within the organization. If leaders were to be effective and achieve organizational goals, they were confronted with the essential requirement to effectively involve followers. A variety of leadership styles were identified depending on the organization types and environment (Bass, 2008).

Bernard Bass explains that until the late 1940's, personal traits were the focus of most leadership theories. In his book, *The Bass Handbook of Leadership, (*2008) he discusses the changes in focus over a period regarding leadership theories. He notes the evolution of change from the 1960's to the early 1980's; the focus on personality characteristics to personal styles to the leadership theories of inspiration and transformation. Through the 1990's leadership theories, traits of leader's and attributes of followers have been widely researched.

The history of cross-cultural leadership cannot be appropriately discussed without understanding the meaning of culture. The two terms most often cited in the literature are diversity and multicultural. In his book, Leadership, Theory and Practice, Northouse explains that diversity refers to the existence of different cultures or ethnicities within a group or organization; multicultural implies an approach or system that considers more than one culture (Northouse, 2013).

Many scholars have developed cross cultural models as organizing frameworks for addressing cultural competence. The publications of Campinha-Bacote (2002), Purnell and Paulanka (2003), Giger and Davidhizar (2004) as well as the seminal work of Spector (2004) and Leininger and Mcfarland (2002) have shaped debate on matters of cultural competence in nursing and healthcare (Watts, et al., 2008). Diversity and cultural competence discussions are more widespread than ever with the changing demographics in the United States. The environment demands change and those in leadership must develop strategies to meet the organizational needs of all stakeholders.

The diverse groups represent diverse needs. The multicultural beliefs, behaviors, and actions of each present unique challenges. Bass notes that multicultural groups can be either highly effective or highly ineffective (Bass, 2008). His book, *The Bass Handbook of Leadership*, discusses the works of Gordon and Loden (1989) and the need for pluralistic leaders. These individuals must support diversity at all levels of the organization while being ethically committed to both fairness and the understanding of underlying differences between people.

Northouse acknowledges that globalization has been advancing throughout the world since World War II (Northouse, 2013). He eloquently discusses the belief that individuals tend to place their own group at the center of observations of others and the world. Referred to as ethnocentrism, the perception that one's own culture is better than another creates tremendous obstacles for leadership.

A multitude of studies have been completed addressing the issue of culture characterization. When discussing culture, Geert Hofstede's work, Cultures and Organizations: Software of the Mind, (1991) is the most referenced and is the benchmark for most research on world cultures. He identified five major dimensions of which culture differ: power distance, uncertainty avoidance, individualism-collectivism, masculinity-femininity, and long-term-short-term orientation (Northouse, 2013).

The GLOBE studies, Global Leadership and Organizational Behavior Effectiveness research program have produced significant findings related to the relationship between culture and leadership. The GLOBE research project was initiated by Robert House in 1991 and continues today involving more than 160 investigators. The purpose of this research is to increase understanding of cross-cultural interactions and the impact on culture and leadership effectiveness (Northouse, 2013).

There are differences among the terms related to an understanding of culture and becoming culturally competent. Culture is defined as the customary beliefs, social forms, and material traits of a racial, religious, or social group (Merriam-Webster, 2020). "Cultural competence is an acknowledgement and incorporation of, on the part of clinicians and healthcare systems, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs' (Kodjo, 2009).

The need to embrace diversity and cultural competence among our leadership teams requires transforming organizations. Reforming beliefs is critical for transformational success including outcomes improvement and cost reduction. Leaders will need to hone a unique skill set to be effective in the organizations of today. This requires proficiency in an array of competencies. Armada and Hubbard (2010) discuss three key issues encompassing cross-cultural healthcare; racial and ethnic disparities in th equality of the healthcare provided to minority patients; and providing language access and assistance to limited English proficient (LEP) and disabled persons.

A crucial step in increasing cross-cultural competence in the healthcare arena demands that patients also have a voice. The American Hospital Association (AHA) convened the Special Advisory Group on Improving Hospital Care for Minorities in December 2007. The group's mission was twofold; one, to study how to improve hospital care and eliminate disparities among minority populations; and two, to ensure that racial and ethic minorities have a voice in national healthcare reform (AHA, 2008). The move for accrediting bodies to mandate standards for cultural competence has been identified in Armada and Hubbard's 2010 paper entitled, Diversity in Healthcare: T*ime to Get REAL!*. The article noted that 19 states implemented state-based mandates as of 2010 requiring them to collect data on race and ethnicity in hospitals. In 2009, The Joint Commission, the National Committee on Quality Assurance, and the national Quality Forum all issued draft statements proposing cultural competence standards for healthcare organizations, health plans and hospitals.

There are known barriers to collecting data on race and ethnicity. The perception that discrimination in providing care is of concern, the fact that patients may be offended or not provide accurate responses and further, that hospital personnel may be uncomfortable asking questions related to race or color (Armada and Hubbard, 2010). This level of sensitivity among healthcare providers may speak to their caring nature, however, it impedes progress in addressing the needs of the diverse populations served.

Language access issues must be confronted on behalf of limited English proficient (LEP) and disabled persons. Approximately 22 percent of the United States population do not speak English at home, and this number

increases to 29 percent in Florida and 31 percent in Nevada. In addition, people with hearing deficiencies require language access, and this group represents approximately 3.6 percent or 10 million people in the United States. These issue us be addressed because they directly correlate to quality and safety (Armada and Hubbard, 2010).

Successful change in healthcare organizations require leaders with strong cross-cultural competence and personal motivation to learn and acknowledge their own shortcomings. Formal training to increase cross-cultural awareness and multicultural acumen may be needed among leadership and eventually throughout the organization. To meet the demands of current workplace diversity exceptional communication skills are crucial for leadership. To effectively lead others, leadership must honestly evaluate their personal knowledge of multicultural issues such as gender, ethnicity, religion, sexual orientation, and generational differences (Weech-Maldonado, 2012).

Research demonstrates that the Chief Executive Officer's (CEO) involvement in cross-cultural issues is beneficial to the organization. Armada and Hubbard's (2010) research also discussed findings of the Gallup Organization in 2011 who found that CEO commitment to diversity resulted in twice the job satisfaction of companies with CE's who lacked the same commitment (58 percent vs. 24%). Moreover, retention levels within CEO-supportive organizations were close to a third higher than other companies (81 percent vs. 60 per cent) as the statistics confirm (Armada and Hubbard, 2010).

There are inherent challenges to developing the culturally competent environment for CEO's. Workforce diversity, Employment Equal opportunity and Affirmative Action compliance, and sexual orientation sensitive issues are often addressed by Human Resources. The diversity agenda among employees is different than the diversity agenda driven by clinicians who focus on improving outcomes, quality, and safety, reducing disparities, and promoting patient equality. Leadership must be strategic if they want to unite the stakeholders and meet a standard o excellence in cross-cultural competence. In addition, leadership must differentiate between Organizational, Systemic and Clinical cultural competence (Sfantou, 2017).

Multiple issues influence the likelihood that healthcare leaders will male transformational changes in their healthcare systems. First, leaders must know what their patients need and who they are. This requires collection of patient race, ethnicity, and language data. According to David Hunt, president and CEO of Critical Measures, a leading consulting firm addressing racial and ethnic disparities in healthcare, leadership is the key factor in requiring that this data be collected. Hunt acknowledges that he has clients that stratify patient satisfaction data by race and language. The results demonstrate striking differences inpatient satisfaction. Patients of color were twice as likely as whites to not have confidence in their doctor, two to three times as likely to rate the courtesy of the doctors, nurses, and other staff as 'fair or poor' and substantially more likely to say that they were not treated with dignity and respect (Armada and Hubbard, 2010).

Reeleder, Goel, Singer, and Martin (2006) expend considerable print to leadership perspectives and priority setting. A qualitative study involving interviews with 46 Ontario hospital CEOs as performed to define the role of leadership in priority setting through the perspective of hospital leaders. The authors report a framework of leadership domains to include vision, alignment, relationships, values, and process to facilitate priority setting practices in health services' organizations. The study provides a leadership guide for decision makers to improve the quality of their leadership, and in the researchers' opinion, fairness of their priority setting (Reeleder, 2006).

3.2 Diversity

With respect to stewardship and courage in the executive suite, the article written by Andrea Coleman (1998) details the importance of leaders possessing characteristics often identified in the leader. Commitment to stewardship, building and instilling hope, their work is a vocation. Coleman maintains that to successfully change the culture of an organization in turbulent times the leader's purpose must be transcendent and inspire others to sacrifice for the common good. Although written more than twenty years ago, the article's message is relevant in today's multicultural healthcare environment. Managing a culturally diverse workforce is challenging, especially with widespread healthcare provider shortages. The legacy leader could be influential in guiding managers through the difficult demands associated with workforce diversity and shortages.

There is evidence in the literature to support Coleman's opinion. In 1999, Francis Hesselbein wrote, *"The Key to Cultural Transformation"*, discussing findings in great organizations. He notes for institutions that make diversity and inclusiveness high priorities, productivity is not measured by the efficiency and quality of services performed alone. He offers multiple key measurements to assess promotion of diversity including the quality of the interactions between individuals and the groups. The success of efforts to honor differences, and most importantly, the ability to recruit and retain a more diverse workforce at every level (Clapp, 2010).

The literature confirms the importance of managing workforce diversity. Much emphasis is placed on the CEO's commitment and management style linked to successful outcomes of managing diversity in multicultural organizations. Diversity in the executive suite cannot be overlooked; and the range of leadership behavior and decision making has resulted in countless empirical studies on management styles. In the article, "Leading Change in Diversity and Cultural Competence", Mary Lou de Leon Siantz acknowledges that Chief Diversity Officers are now in the C-Suite, the highest level of the organization. Companies including Ford, IBM and Merck all have Chief Diversity Officers working directly with leadership. Her research focuses on nursing; however, the findings are relevant for all disciplines by claiming a critical need exists for culturally competent skill development for patient care, health systems, curriculum, research, recruitment, and retention (Siantz, 2008)

All leaders and organizations should acknowledge the vast disparities found between generations and commit to culture change modifications. *"Converging values: matures, boomers, xers, and nexters in the health care workforce",* authored by Parsons in 2002 purports that time must be allocated to fully understand the differences between generations. His search suggests that a successful leader will try several strategies to bridge the generational gap and the use the expertise of each cohort group to facilitate change. Parsons defines the distinction among generations and the skillset that each group offers an organization. He states, "The energy, techno literacy, and commitment to a balance between work and personal time by the Generation X and Nexters will complement the wisdom and nursing experience of the Mature and Baby Boomer generations. Recognizing differences and appreciating the expertise that everyone brings to the workplace will create an environment that embraces generational diversity. Celebrating individual differences comes from taking time to learn about coworkers and will help enhance health work environment (Parsons, 2002).

Although the majority of people are influenced by their culture, they are not always aware of its effect on their beliefs, values, and behaviors. Nor are employees aware of the message they may be sending. The rise of diversity initiatives and workforce training in organizations should help to create awareness among individuals. Church, Katigbak, and Prado (2010)

completed extensive research testing multiple hypotheses of cultural situational, and trait effects in the United State and the Philippines. The findings demonstrated patterns of both cultural similarities and differences in how situations are perceived. One finding noted interactions with casual acquaintances were perceived as more like interactions with strangers by Filipinos, as compared to Americans. The study is of particular interest given the recruitment of Filipino nurses to address the nursing shortage in the United States.

3.3 Culturally Competent Healthcare Organizations

The former president and CEO, Tim Hanson, of HealthEast Care System in St. Paul, Minnesota conducted a cultural competence organizational assessment based on the Department of Health and Human Services (DHHS) Culturally and Linguistically Appropriate Services (CLAS) standards. He then made changes immediately based on issues discovered in the assessment. The organization hied a significant umber of interpreters, improved written translation materials and hospital signage; trained physicians and nurses to work with interpreters and to comply with federal and state language access laws. HealthEast conducted a system-wide employee opinion survey on diversity issues, then stratified results by race, gender, and location. Emergency room physicians and nurses were trained on Quality Interactions (Armada and Hubbard, 2010).

HealthEast's success serves as an example for other institutions. They tied diversity to the achievement of larger organizational goals; for example, patient quality and safety, employee engagement and productivity. Being more focused on providing high quality, culturally responsive patient care, HealthEast increased its impatient market share by 33 per cent and achieved its strategic goal of being the benchmark for quality I the Twin Cities by 2010. A study by Reuters ranked HealthEast one of the top ten hospital systems in the United States in 2009 (Armada and Hubbard, 2010).

"Diversity leadership: The Rush University Medical Center Experience" authored by J.R Clapp, the former Senior Vice President for Hospital Affairs at Rush University Medical Center, chronicled the journey from discovery of the need for culture change to outcomes. Clapp recommends that diversity initiative responsibilities are clarified to ensue all goals and objectives are achieved. He concluded that successful outcomes require clear and consistent communication from organizational leaders. Moreover, that tactical approaches, proactive senior leadership, the Diversity leadership Group Model, and accountability across Rush University Medical Center were key components to success. Clapp (2010) summarizes steps to cultural competence stating, "Eliminating exclusion, bias and misunderstanding based on people' differences is not a simple matter of instituting some, correct set of policies and procedures. Equity and diversity are achieved through changes in attitudes, habits, and society – changes influenced not only by organizational policies, but by the factors the institution cannot control."

A case for diverse teams is acknowledged in "Racial and ethnic diversity and organizational behavior: a focused research agenda for health services management, research completed by Dreaschlin, (et al., 2004). The article notes that when senior management is primarily white it may be out of touch with culture context of the patient population and workforce. Furthermore, patients and employees from the same racial and ethnic group are likely to share similar perceptions of the organization, whereas racial groups seem to have difficulty perceiving and understanding the experiences of other racial groups.

3.3.1 Culturally Linguistically Appropriate Services (CLAS)

The CLAS standards were published on December 22, 2000, in the Federal Register, for adoption by healthcare organizations and other stakeholders to address and correct the inequities that persist in the delivery of healthcare. The stakeholders involved in the development of CLAS included healthcare providers, consumers, hospitals, community-based clinics, state and federal agencies, policymakers, accreditation and credentialing agencies, advocacy groups, and educators. The involvement of multiple stakeholders provided perspective on existing measures, the diverse population impacted and helped to illustrate the type of guidance and training that was needed in the healthcare delivery system (Office of Minority Health, 2001). In 2013, the U.S. Department of Health and Human Services Office of Minority Health released the enhanced National CLAS Standards to guide health and health care organizations in their efforts to ensure health equity (CMS, 2016).

There are 14 CLAS standards approved and represent four specific themes: (1) Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). The standards establish fundamental requirements to base activities with the intent to consider values, preferences, and expressed needs of the consumer of health services. The delivery of healthcare should consider an individual's preferred language and cultural beliefs. To achieve optimal patient outcomes communication that is clear between patient and the provider is necessary (U.S. Department of Health & Human Services, 2017).

The implementation of CLAS standards and cultural competency are important components of patient communication. The National Quality Forum (NQF) defines cultural competency as the "ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable." (Weech-Maldonado, et al., 2012). As the United States demographics continue to change with an influence on minority growth, consistency within an organization is important as it appears to influence patient outcomes and the workforce.

To illustrate, California, is one of the most diverse and populated of the United States regarding ethnicity, language, and race. The California Department of Finance predicted in 2013 Hispanics would outnumber whites in California by 2014. The Hispanic/Latino population experienced the most growth between 2010 and 2021 increasing from 14.1 million in 2010 to 15.8 million in 2021. In 2021 the white (non-Hispanic) population made up 35.2 percent compared to 40.2 percent in 2010. Thus, 2021 census statistics confirm that Hispanics/Latinos do outnumber whites in California (USAfacts, 2022).

Further, the U.S. Census Bureau reports the population of people who are two or more races is projected to be the fastest growing group over the next few decades. Of note, the nation's foreign-born population is expected to grow by 1.8 million people per year between 2017 and 2060. This represents a rise from 44 million people in 2016 to 69 million in 2060 (Vespa, Medina & Armstrong, 2020).

3.4 Challenges: Promoting Diversity & Blending Cultures

Determining the mission, goals, visions, and objectives of an organization are imperative to communicating effectively with stakeholders. This ultimately determines what your organization is, what it stands for and where you want to go. To lead effectively, followers need to understand how the organization is defined and strategic leadership is a component of this equation. In their article, *"Strategic Leadership: Values, Styles, and Organizational Performance",* (2013), Carter and Greer investigate the relationship between strategic leadership and stakeholders noting that strategic leaders are being increasingly squeezed by the conflicting demand of

stakeholders. They offer extensive details to support the increased challenges of multiple and sometimes conflicting expectations that leadership must confront and resolve. The variations in leadership styles and traits are outlines and compared. Of interest to the blending of cultures is the echelon theory of leadership discussed in this paper. Several studies have supported the relationship between upper echelon characteristics and organizational strategies and performance. The information presented by Carter and Greer suggest that the demographic diversity represented in upper echelons should have positive outcomes for diversity-related issues within organizations.

In their article, *"Culture change, leadership and the grass-roots workforce"* (2014), Edwards, Penlington, Kalidasan and Kelly discuss the leadership style within the national Health Services (NHS). The NHS utilizes a collaborative process that engages with the workforce rather than the more traditional top-down approach. In addition, the NHS considers the cultural diversity of local organizations and professional groups to identify the multiple aspects of a potential solution in transforming an organization. The authors maintain that modern healthcare requires and in depth understanding of the leadership style necessary to successfully implement cultural change in organizations.

An important starting point is to clarify the values of cultural competence. Examination of the literature reveals a strong mandate to remove barriers of access to medical care and to eliminate health disparities. Dreaschlin, Hunt and Sprainer (2000) discuss their extensive research in their publication, "*Working diversity: implications for the effectiveness of health care delivery teams"* claiming that as the demographics change in the United States more focus is placed on the role of workforce diversity team processes for clinical decision making and health care delivery. The studies they conducted revealed that team members see the team's interactions from different perspectives that are so strongly influenced by the member's racial identity. Collaboration, service, and commitment are necessary components to integrating teams.

3.5 Impact on Quality

Dreaschlin et al. (2000) quoted research by Mazevski in 1994, "the common element in high performing groups with a high member diversity is integration of the diversity. In all studies, diversity led to higher performance only when members were able to understand each other, then combine and build on each other's ideas." His research offered a comprehensive review of research spanning 40 years on the demographics and diversity in organizations. A collaborative approach s a prerequisite to engage the workforce and transform the organization. Introducing new policies, approaches and changes to stakeholders demands effort, communication, and consistency.

In the article, *"Tainted vison: the effect of visionary leader behavior and leader categorization tendencies on the financial performance of ethnically diverse teams",* Greer, Homan, De Hoogh and Den Hartog (2012) discussed the organization's financial performance based on the leaders' approach and management styles. Their research is successful in illustrating that when leaders exhibit visionary behaviors leading ethically diverse teams there is buy-in from the stakeholders translating to positive financial outcomes. The savings associated with workforce retention are significant and translate to the bottom line. The importance of diversity within the organization and the contribution from ethnically diverse teams could offer the organization impressive opportunities.

The expansion of cultural knowledge in conjunction with the dynamics resulting from cultural differences could lead to respect and empathy among all stakeholders. Moreover, improved health outcomes and subsequently, an improvement in patient safety will result (Kodjo, 2009).

To illustrate, the Journal of Patient Safety revealed that each year preventable adverse events (PAEs) resulting from hospital medical errors are now the third leading cause of death in the United States according to research completed by Dr. James from the advocacy group, Patient Safety America. Based on the weighted average of four studies utilizing the Global Trigger Tool, James concluded 210,000 deaths are preventable in hospitals annually (James, 2013). Communication problems are among the root causes of 59 percent of serious adverse events reported to the Joint Commission's Sentinel Event Database in 2012 (Joint Commission, 2016). Kodjo (2009) suggests that the healthcare providers commitment to culturally competency could be demonstrated by diversifying staff, employing protocols that are inclusive and respectful to other cultures, and this includes the office environment overall.

4 Leadership

4.1 Leadership Approaches

The leader's role has multiple aspects and requires key competencies. Of note is the ability to influence group activities. Leaders need to engage staff, capitalize on organizational diversity, and utilize resources to effectively design management processes. There are several leadership theories and styles that continue and change over time (Al-Sawai, 2013). To ensure teams are effective, they need support from the leadership in the organization. When leaders effectively engage teams, they foster trust and empower their teams to express and share ideas (Rahmadani, 2020). When leaders engage teams the impact on each team member is significant. Of importance, when the leader engages their employees by delegating responsibility the employee feels more competent after each task. This is a leadership behavior known as strengthening (Schaufeli, 2021).

4.2 Leadership Competencies

Between 2000 and 2009, the Center for Creative Leadership engaged 34,899 healthcare-sector organizations to complete a feedback survey examining the relationship between importance rankings and effectiveness rankings. The group demographics had an average age of 44, 25 percent were top management and executives, 55 percent middle and upper-middle management with 10 percent frontline and hourly workers. There were 16 key leadership skills found. Three important to this research study included: 1- Change Management (using effective strategies to facilitate organizational change initiatives and overcome resistance to change), 2- Differences Matter (demonstrates a respect for varying backgrounds and perspectives and values cultural differences), and 3- Participative Management (uses effective listening skills and communication to involve others, build consensus and influence others in decision making). The overall top priority for leadership development in the healthcare sector is to improve the ability to lead employees and work in teams (Patterson, et al., 2020).

5 Gaps in Research

There are gaps identified relating to the impact that cross-cultural leadership has on organizational outcomes. Research on diversity management and its relationship to racial and ethnic disparities in the workforce is

available. Based on current information there is an abundance of diversity courses available online, workforce diversity training, tools to engage employees and several ways to increase a customer base. There are companies offering to transform workforces to become more engaged over a one-to-three-year period, however, timeline to successfully transform organizations to become culturally competent and maintain a standard of excellence in organizational diversity is extremely limited. Most likely a result of the number of barriers and ongoing challenges, such as though related to population diversity.

6 Conclusions

According to the literature reviewed, there is a consensus that education and training related to workplace diversity among leaders, staff and other stakeholders is imperative. In addition, cultural competence criterion needs to be understood and implemented across all organizations, especially in healthcare, if there is to be a level of consistency and standard for comparative analysis. Employee engagement and buy-in improves when leaders exhibit proficiency in leading ethnically diverse teams. Behaviors and attitudes and the resulting culture within an organization sends a message to all stakeholders. As such, it is imperative to remember that cultural competence is a process, not an end point. The organization needs to have an ongoing plan for improvement. All leaders need to be skilled at leading and managing people of different cultures; while it is essential that they listen to the voices of the people they lead, they must also understand what those voices may actually be telling them.

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