The Wisconsin Diversity Assessment Tool (WI-DAT):

A vision for sustainable change

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The purpose of this paper is to present a comprehensive, standardized diversity assessment tool with recommendations for follow-up. This tool provides an integrated outcomes–focused approach to consistently assess, monitor and evaluate the status of diversity within nursing education programs, health systems and other healthcare organizations to enhance and ensure a sustainable and diverse nursing workforce for the people of Wisconsin.

Background and Justification

Diversity is one of the most controversial and least understood topics. Efforts to create meaningful change have been elusive. Diversity training began in the 1960's to meet regulatory compliance surrounding the Civil Rights Act of 1964. During the early 1980's the expectation of business was that racial and ethnic minorities would assimilate into the corporate culture. In the late 1980's, the discussion shifted again due to a lack of successful transition of women and minorities into a corporate culture and to meet affirmative action requirements. Inclusion entered the discussion in the late 1980's and 1990's with a focus on sensitivity training, addressing inequities and using social justice as a guide (Anand & Winters, 2008).

Analysis of these historic shifts resulted in the identification of three paradigms; discrimination and fairness, access and legitimacy and learning effectiveness. All of these appear today as guiding tenets for the diversity-oriented conceptual frameworks/models in education, healthcare, and corporate America (Anand & Winters, 2008; Drumgo & Ramos, 2014; Thomas & Ely, 1996, Williams, Berger, and McLendon, 2005).

Current Status

Workforce

The United States is at demographic crossroad as over 50% of children one-year-old and younger are now from nonwhite racial and ethnic groups; currently one in three Americans is a member of a racial and /or ethnic minority and it is projected that by 2043 there will be no majority population in the United States (The Sullivan Alliance 2014; U.S. Census Bureau, 2012). The expectation for the workforce in the 21st century is cross-cultural competence in an increasingly global society (Anand & Winters, 2008).

The benefits of increasing diversity have been well documented in the business sector. Diverse companies generated 18% higher productivity than that of the U.S. economy overall (National Urban League, as cited in Coffey, 2011). The American Sociological Association (cited in Coffey, 2011) found companies with the highest levels of racial diversity averaged 15 times more sales than those with lower levels. Drumgo and Ramos (2014) reported a sales increase for each 1% in racial diversity in the workforce. Jimenez, the Chief Diversity Officer & VP-Diversity and Inclusion of Wellpoint (Worth, 2009, p.5) stated,

> Inclusion makes a corporation resonate so they not only look like the communities they operate in and the customers they serve, but they think and act like them too… That is what is going to drive business performance…WellPoint has seen steady, incremental progress in its diversity initiatives in recent years…With diversity comes innovation and creativity…Diversity makes us react and think differently, approach challenges and solve problems differently, make suggestions and decisions differently and see different opportunities. Superior business performance requires diversity of thought and tapping into unique perspectives.

Businesses in Wisconsin are leading efforts to diversify their workforces. Leaders in Wisconsin include but not limited to Alliant Energy, Anthem Blue Cross Blue Shield, Spectrum Brands, Exact Sciences, and UW Health/Unity Insurance in Wisconsin (Diversity Inc., 2014; Urban League, 2013).

Education

Primary and secondary educators across the country have struggled to provide racial and ethnic minorities with the skills to meet the needs of the workforce, in an educational system that was often substandard and inequitable (Institute of Medicine [IOM], 2004). Due to these historical inequities, the pipeline of well-qualified diverse students arriving to the health professions has been minimal. There was one positive shift, a significant number of women moved into male-dominated health care professions. The exception is the nursing profession which has experienced little progress towards racial, ethnic, and gender parity (National Center for Educational Statistics [NCES], 2008; U.S. Census, 2010; Williams, Berger, & McLendon, 2005). In Wisconsin, the University of Wisconsin System has taken a lead role "to establish a comprehensive and well-coordinated set of systemic actions that focus specifically on fostering greater diversity, equity, inclusion, and accountability at every level of university life" including colleges of nursing (2014, p.1).

Healthcare

The U.S. healthcare workforce does not reflect the patient population being served and will fail to meet the needs of an increasingly diverse nation if sustainable change does not take place. Currently only 12.3% of physicians, 7% of dentists, 10% of pharmacists, and 11% of Registered Nurses (RNs) are of a racial or ethnic minority group. Men represent only 9% of full-time RN's and 6.9% of the nursing workforce in Wisconsin and there is a need to consider men

as an underrepresented population in the nursing profession (Bleich, MacWilliams, & Schmidt, 2015; Buerhaus, 2009; NCES, 2008; U.S. Census, 2010; Wisconsin Center for Nursing 2013b).

The best evidence supports that "diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students" (IOM, 2004, p.1). AACN (2008) states that the "increasing globalization of healthcare and the diversity of this nation's population mandates an attention to diversity in order to provide safe, high quality care."(p. 7). Meeting the needs of a more diverse patient population is a matter of patient safety and satisfaction; the business of healthcare delivery is often measured in these terms. The U.S. nursing workforce remains predominately white and female; there has been minimal movement towards a workforce that mirrors the diverse populations for which it provides care.

Diversity planning should address local need but must be delivered in an integrated and systemic manner that results in regional, national and international sustainability (IOM. 2004; Sullivan Alliance, 2014; Sullivan & Mittman, 2010; Sullivan Commission, 2004; Wisconsin Center for Nursing [WCN], 2013a; Yang & Konrad, 2011). The Robert Wood Johnson (RWJ) Hospital System (2014) identified the need to ensure that diversity and inclusion is "woven into the fabric of everything we do"…and serves to "foster a culture of dignity, innovation and cultural effectiveness." The integration of diversity and inclusion into all facets of an organization creates a seed for cultural humility to grow, the potential for competency to emerge and an inclusive organizational culture to flourish.

Diversity measurement is needed if sustainable change is going to occur. According to a New York Times (2007) survey of 265 Human Resource professional and diversity specialists, the priority diversity activity in the workplace was building diversity metric/measurements.

Sustainable change must be measurable and permeate the organizational culture in a continuous quality improvement process; this holds true in workplaces and educational settings (Drumgo & Ramos, 2014; Glickman, Baggett, Krubert, Peterson, & Schulma, 2007; Williams, Berger, and McLendon, 2005).

Definitions of Diversity and Inclusion

The American Association of Colleges of Nursing (AACN, 2008, p. 37) defined diversity as "The range of human variation, including age, race, gender, disability, ethnicity, nationality, religious and spiritual beliefs, sexual orientation, political beliefs, economic status, native language, and geographical background." The RWJ Foundation (2013) values differences among individuals across multiple dimensions including, but not limited to, race, ethnicity, age, gender, sexual orientation, physical ability, religion and socioeconomic status. The RWJ Foundation views diversity and inclusion as core values that are a reflection of their Guiding Principles.

The Association of American Colleges and Universities (AAC&U) defines "diversity as individual differences (e.g., personality, learning styles, and life experiences) and group/social differences (e.g., race/ethnicity, class, gender, sexual orientation, country of origin, and ability as well as cultural, political, religious, or other affiliations). Inclusion is "used to describe the active, intentional, and ongoing engagement with diversity–in people, in curriculum, in the co-curriculum, and in communities (intellectual, social, cultural, geographic)."(AAC&U, 2014 p.1). In the Diversity Maturity Model (DMM), adopted by Lockheed Martin Diversity and Blue Cross Blue Shield of North Carolina, diversity is linked to the business mission of building a mature and sustainable workforce ("Profiles in Diversity", 2014; Lee, 2007; Lockheed Martin, n.d.). Diversity is defined as an "inclusive team that values and leverages each person's individuality." (Lee, 2007, slide 5). The corporate mission is "One Company, one team, all-inclusive, where

diversity contributes to the Lockheed Martin vision." (Lee, 2007, slide 5). The educational and business models share the three guiding paradigms; discrimination and fairness, access and legitimacy and learning effectiveness that serve as the basic conceptual framework (Drumgo & Ramos, 2014; Thomas & Ely, 1996; Williams, Berger, and McLendon, 2005). The common thread throughout all of these examples is that the definitions of diversity and inclusion are broad but specific to the type and mission of the organization.

Conceptual Frameworks and Models

Four conceptual frameworks or models were used when developing the Wisconsin Diversity Assessment Tool. The IE model was used as a model for diversity in nursing education. The DMM model has been used in healthcare organizations. Both frameworks are similar because they emphasize the need to integrate diversity efforts throughout the organization in a sustainable manner. They define different dimensions or facets; IE addresses aspects of higher education; DMM focuses on workplace characteristics. The third model, the Donabedian structure-process-outcome model for quality, was used as a framework for organizing the metrics. Lastly, the cultural humility model was used as the cultural framework for the Wisconsin Diversity Assessment Tool (Williams, Berger, and McLendon, 2005).

Based on research, IE intermingles diversity and quality into the core functions of an educational institution. Many higher education institutions across the country have adopted this framework (AAC & U, 2014b; Williams, Berger, & McLendon, 2005).

In the IE model, diversity is considered a critical component of an integrated, multidimensional plan. Four areas are addressed in planning, action, and sustained monitoring of diversity efforts: (1) access and equity, (2) campus climate, (3) diversity in the formal and informal curriculum, and (4) learning and development. A top-down and bottom-up approach is

used to create integrated systemic change in all university units, including colleges of nursing (AAC & U, 2014b; Williams, Berger, & McLendon, 2005).

In the DMM model, measurement occurs in four areas: workforce, workplace, marketplace, and community. The diversity maturity of the organization in these areas is assessed as Stage 1 Foundational, Stage 2 Enlightened, Stage 3 Integrated or stage 4, Optimized Inclusion. Actions are taken using an integrated approach (Drumgo & Ramos, 2014).

Donabedian proposed attention to structure, process, and outcome measures in quality initiatives. Therefore, his framework was used to format the Wisconsin Diversity Assessment Tool. Evidence has supported this quality framework; however, considering a broader range of healthcare organizational structures has been recommended (Glickman et al., 2007). Therefore, the dimensions included in the IE and DMM models were incorporated into the Wisconsin Diversity Assessment Tool.

Cultural competence has been used in an integrated systems approach that could serve to guide all the health care professions within the health care system (Betancourt, Green, & Carillo, 2002). Cultural competency requires cultural humility. Therefore, cultural humility was selected as the cultural framework for the Wisconsin Diversity Assessment Tool. Cultural humility is defined as the lifelong commitment to self-evaluation and critique that addresses the power imbalances found in faculty, student and patient interactions with the goal of creating a mutually beneficial bidirectional partnership (Chang, Simon and Dong, 2014; Freire, 1970; Hunt 2001; Tevalon & Murray-Garcia, 1998). The intentional integration of diversity and inclusion begins with a humble persona that allows healthcare professionals, patients, and peers to learn from each other, to develop meaningful partnerships that are inclusive and provide the individual capacity to develop cultural competency. Cultural humility serves to keep a focus on the power-

centered relationship; there is a difference when persons in dominant and minority cultures interact. In contrast to entitlement, a nurse with cultural humility embraces a sense of selflessness and equity.

Metrics

The metrics included in the Wisconsin Diversity Assessment Tool are presented below (see Table 1). These began with a comprehensive review of the diversity literature that included over 110 peer-reviewed articles and books from academic and business sources. Best practices were identified and measurements were developed. The tool was framed using Donabedian's structure-process-outcome approach to assist readers in achieving measurable sustainable change (Glickman et al., 2007; Schmidt & MacWilliams, 2015). The measurements are designed to be used in any setting. Specific examples are offered to assist in understanding how the metrics could be applied within individual organizations.

Table 1. Wisconsin Diversity Assessment Tool

Outcome Metric	Structure Metric	Process Metric	Evidence/exemplars
The institution/ organization meets legal and accreditation standards related to diversity and inclusion.	Policies are present that meet regulatory standards related to diversity.	Processes are identified that ensure compliance to regulatory and accreditation standards. Accreditation activities include efforts to increase diversity in nurses, students, or faculty.	AACN (2008) American Assembly for Men in Nursing (2013) IOM, 2004 NLN (2002) Toney (2012) United States Department of Health and Human Services Office of Minority Health (2001)

Nursing students/nurses and nursing faculty resemble the diversity of the surrounding area or service area		Environmental assessment completed by state or region related to composition of service area. Completed analysis of nursing students, nurses, and faculty in organization or institution (e.g. percent of students faculty or nurses from underrepresented groups). TUGS (targeted underrepresented groups) are identified as opportunities to increase diversity in organization.	IOM (2004) IOM (2010) Lewis (2010) Schmidt & MacWilliams (2015) United States Department of Health and Human Services Office of Minority Health (2001) WI Center for Nursing (2013a)
Nursing students, nurses, and faculty report fair and comfortable climate in organization without offensive, hostile, intimidating, discriminatory, or exclusionary experiences (these may be expressed as micro-inequities)	Written code of conduct addresses behaviors of equality, inclusion, and cultural humility.	Annual climate survey or alternate assessment (e.g. focus group/exit interviews, electronic polling) are conducted. Identified inequities are addressed as part of a cyclical QI process Processes are in place for confidential reporting and follow-up on	Barton & Swider (2012) Dickens, Levinson, Smith, & Humphrey (2013) Fuller (2013) Harvey, Robinson, & Frohman (2013) Lockheed Martin (n.d.) McConnell & Reams (2012)

		incidents of offensive, hostile, intimidating, discriminatory, or exclusionary treatment of students, nurses, or faculty	NLN (2009) Naplerkowski & Pacqulao (2010) Sayman (2014) Scheele, Pruitt, Johnson, & Xu (2011) Schmidt & MacWilliams (2015)
Diversity efforts are integrated throughout all levels of organization and involve community of interest	Mission/vision/values address diversity and inclusion. Written individualized diversity strategic plan is present with accountabilities/timeline, monitoring, dedicated resources, and follow-up. TUGS (targeted underrepresented groups) are present in leadership positions and decision-making bodies (e.g. boards, committees). Support systems are present for TUGs (e.g. orientation, mentorship, financial aid, support groups). Reward systems reflect inclusive behavior (e.g. performance appraisal/wage increase, promotion, tenure, student evaluations, support for	Educational strategies are implemented related to diversity: (e.g., communication, conflict management, values and behaviors, teamwork, diversity policies, benefits of diversity, cultural humility, student-centered pedagogies) Stakeholders at all levels of organization (including senior leadership and community partners) are involved in diversity efforts. Strategies to promote recruitment of TUGs in students, nurses and faculty are implemented	AACN (2014) Ackerman-Barger (2010). Adeniran & Smith-Glasgow (2010) Alicea-Alvarez (2012) Barra (2013) Barton & Swider (2009) Beacham, Askew, & William (2008) Bednarz, Schim, & Doorenbos (2010) Bleich et al. (2015) Brenman, (2012) Campbell (2009) Chandler & Swanston (2012) Chang et al. (2012) Chege & Garon (2010) Degazon & Mancha (2012) Drumgo & Ramos (2014) Duerksen (2013) Escallier & Fullerton, (2009) Fettig & Friesen (2014)

	professional development.	(e.g. promotional activities and materials; outreach to elementary, middle, and high schools; comprehensive admission criteria; and/or partnerships with minority organizations). Annual comparison of success of TUGs with majority group is conducted (e.g. retention, NCLEX pass rates). A hiring or admission process survey is conducted and analyzed at least annually.	Friday & Friday Gates & Mark, (2012) Georges (2012) Gilliss, Powell, & Carter (2010) Gordon & Copes (2010) Igbo et al. (2011) Johnston & Mohide (2009) Juarez (2006) Kawi & Xu (2009) Lee (2007) Loftin, Newman, Bond, Dumas, & Gilden (2012) Loftin, Newman, Gilden, Bond, & Dumas (2013) Meadus & Twomey (2011) Melillo, Dowling, Abdallah, Findeisen, & Knight (2013) Moceri (2010) Mortell (2013) NLN (2009) Nease (2009) Nnedu (2009) Peery, Julian, Avery, & Henry (2012) Rearden (2012) Schroeder & Diangelo (2010) Schmidt & MacWilliams (2015) Trossman (2009) Turner, Gonzalez, Wood (2008) Whitman & Valpuesta, (2010) Williams, Berger & McLendon (2005) Wilson, Sanner, & McAllister (2010)

Diversity efforts are sustained within the organization.		Measurement, analysis, and intervention related to diversity and inclusion is conducted on a regular, cyclical basis.	Drumgo & Ramos (2014) Glickman (2007) Villarruel, Bigelow, & Alvarez (2014) Williams, Berger & McLendon (2005)

Recommendations

A set of recommendations was made, based on the literature review and metrics. These recommendations are presented in this section.

Recommendation 1: Develop a standardized system with agreed upon benchmarks for tracking data on under-represented populations in nursing programs and health care systems (IOM, 2010; Wisconsin Center for Nursing, 2013a).

Recommendation 2: Primary and secondary education for many racial and minority groups is far below average (IOM, 2004) and nursing schools should create educational pathways that provide the support needed to facilitate student success and ensure patient safety.

Recommendation 3: The history, experiences and stories of TUG's must be infused into all educational curriculum. Diverse individual perspectives should be viewed by faculty, staff and students as essential to inform change and viewed from a filtered lens of cultural humility (NLN, 2009).

Recommendation 4: Diversity initiatives should be centered on integrated and sustainable partnerships and strategies that create a bridge between education and the workforce.

Recommendation 5: Nursing–specific credentialing agencies like Magnet Recognition Program, Commission on Collegiate Nursing education (CCNE) and Commission for Nursing Education Accreditation (CNEA) should take a lead role in formulating and enforcing explicit policy standards to ensure equitable access and treatment of underrepresented groups.

Recommendation 6: Organizational/institutional climate must be assessed on a regular and cyclical basis and identified inequities must be addressed as part of an integrated quality improvement process.

Recommendation 7: The organization/institution should self-regulate by implementing and enforcing a code of conduct to enhance bi-directional communication, teamwork, and collaboration.

Recommendation 8: The experiences of diverse groups are unique and regionally specific; therefore, interventions should be tailored to identify needs in the local area.

Recommendation 9: Develop a research agenda that is focused on creating a diverse nursing workforce pipeline that begins in elementary school and results in the retention of a diverse nursing workforce.

Recommendation 10: Best practices related to diversity need to be documented and disseminated (WCN, 2015). A sustainable diversity intervention and research repository is recommended

Implementation

Identifying stakeholders with a commitment to diversity and inclusion by region in education, the healthcare professions, healthcare agencies and the workforce at large is needed. Creating partnerships between stakeholders who share a long-term commitment and hold a vested interest in diversity creates sustainability. Stakeholder partners that have diversity and

inclusion programs in place are ideal. Unified efforts that begin in elementary school and serve as a bridge to workplaces and communities are critical (IOM. 2004; Sullivan Alliance, 2014; Sullivan Commission, 2004; WCN, 2012). Nurses are in a unique position to lead these efforts; they have been charged with quality, leading change, and advancing health that spans from the bedside to the boardroom (IOM, 2010).

Conclusion

Safe and high quality patient care in any setting is dependent upon nurses delivering care with cultural humility and demonstrating the ability to provide quality care in an inclusive organizational climate. Diversity must be approached in an intentional and measurable manner. Diversity and inclusion have emerged as the conceptual counterweight to inequalities and exclusionary behaviors seen in nursing and been made explicit using a systemic, integrated approach to create sustainable changes that are common to both the education and workplace setting. The metrics identified above were developed, after a comprehensive review and analysis of the diversity literature of peer-reviewed articles, books, and existing educational and business practices that reflect best practices. The use of metrics will enhance organizational outcomes: meeting legal and accreditation standards related to diversity and inclusion; a workforce of nursing students, nurses, and nursing faculty who resemble the diversity of the service area; nursing students, nurses, and faculty who report a fair and comfortable climate in the organization; diversity efforts that are integrated throughout all levels of the organization and involve community of interest; and sustained diversity efforts. “Injustices flourish where the implicit is not made explicit.” (NLN, 2009).

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