

Pathways for Social Equity: An Audit of Bureaucratic Representation, Diversity, and Cultural Competency in Florida Nursing Homes

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Social equity is a central concern in public service provision. As a concept, social equity is comprised of several disparate concepts including representative bureaucracy, diversity management, and cultural competency, each focusing on a specific function necessary for achieving equitable processes, outputs, and outcomes. While many organizations implement reforms across all three of these dimensions simultaneously, existing applications in the literature tend to only focus on one at a time—potentially obfuscating the true impact of social equity reforms within public organizations. By constructing a dataset of over 600 nursing homes in Florida, our descriptive analysis reveals that nursing homes are unrepresentative, lack diversity, and tend to provide culturally competent care in underperforming homes. We further examine the sectoral differences between for-profit homes and not-for-profit. Our article contributes to the literature by providing an in-depth audit of how nursing homes practice representation, diversity, and cultural competency.

Social equity is a central and enduring concept within public administration (Marini 1971). Definitionally, social equity is concerned with “the correction of existing imbalances in the distribution of social and political values. In contrast to equal treatment for all, equity proposes that benefits be greater for those most disadvantaged” (Denhardt 2004, 105). While this definition is broad by necessity, it poses challenges to systematic studies of social equity in the field. Indeed, public organizations can and do pursue several strategies with this aim in mind—whether it is through functions such as structural changes in the law (Kellough 2006), the hiring and retention of underrepresented bureaucrats (Ricucci 2021), diversity training programs (Sabharwal 2014), and conscious efforts to name, blame, and claim social inequities (Gooden 2015). Yet, most applications tend to only focus on one facet of social equity—potentially making marginal, piecemeal inferences while underestimating and obfuscating the true impact of social equity reforms within public organizations.

Rather than treating aspects of social equity within their respective silos, this article attempts to paint a more comprehensive picture of how social equity is practiced within public service organizations through a descriptive analysis of different types of social equity practices. Descriptive analyses are useful for unveiling the state of the world and what is known about a specific phenomenon (Gerring 2012). As King, Keohane, and Verba (2021) state, “It is hard to develop explanations before we know something about the world and what needs to be explained on the basis of what characteristics” (34).

Our empirical case is Florida nursing homes, which provide a salient context for social equity. Nursing home care in the United States is heavily regulated by the Centers for Medicare and Medicaid Services (CMS), which evaluates nursing homes along myriad dimensions of performance, staffing, accountability, and structural integrity. Despite operating across the for-profit and not-for-profit sectors, roughly 70% of services are financed through Medicare or Medicaid making this a highly public context in terms of both

regulatory authority and funding. The very nature of nursing home care is delivered in a “high touch, low tech” environment where service recipients are highly frail, dependent, and vulnerable. Such features of service delivery make administrative inputs and processes especially consequential since mismanagement and the poor utilization of discretion can be incredibly costly in terms of further physical and cognitive decline among residents.

Florida is an ideal context because it has one of the most culturally and linguistically diverse populations in the United States with more than 20% of residents 65 years of age or older. The state is also a microcosm of wider attacks on diversity, equity, inclusion, and justice that have punctuated the decade thus far. As Pandey et al. (2022) state,

The year 2020, contrary to the idea of clear and hopeful vision associated with the numbers 20/20, saw the world enter a dystopian abyss. In the US and worldwide, there was major backsliding on racial justice and gender justice. One outcome of the pandemic described as “shcession” was the devastating economic and social impact on women across the globe. This backsliding has continued into the present times in the US and world over . . . The summer of 2020 saw major protests about the treatment of Black Americans by agents of the state. The brutal murder of George Floyd by Minneapolis police shocked the conscience of Americans and the world. This was particularly painful coming shortly after the murders of Breonna Taylor by Louisville police and Ahmaud Arbery by two White vigilantes. These acts of racist violence in 2020 were followed in January 2021 by an attack on the US Capitol by organized and unorganized White supremacist elements. (387)

The horrific racialized and gendered atrocities, political resistance to DEI, and erosion of affirmative action by the U.S. Supreme Court, coupled with nursing care’s pervasive struggle with systemic racism and bias (see Sloane et al. 2021), motivate our empirical focus and illuminate the urgency of studying these issues.

Our primary pursuit in this article is to provide an inventory or “audit” of social equity practices. This audit provides an opportunity to take stock of where social equity practices stand within Florida nursing

homes and what is potentially at stake if attacks on social equity continue. The analysis draws upon three mechanisms relevant to achieving social equity—representation, diversity, and cultural competency. Each serve as a distinct pathway through which fairness can be more equitably distributed within organizations (e.g., Guy and McCandless 2012). From a human resource management perspective (see Amirkhanyan et al. 2019; Norman-Major and Gooden 2012; Riccucci and Van Ryzin 2017), these “pathways to social equity” provide disadvantaged populations (both in terms of bureaucrats and clients) access to better quality public services, more equitable organizational processes, more resources, and ultimately, better outcomes (see Guy and McCandless 2012; Johnson and Svava 2011; McCandless 2021).

Literature Review

The 1968 Minnowbrook Conference was one of the earliest calls for greater incorporation of social equity as a value in public administration research (Gooden and Portillo 2011; Marini 1971; Stivers et al. 2023). Since then, social equity has been incorporated as a pillar of public administration with scholars increasingly exploring the pathways to enhance social equity across policy issues (Blessett et al. 2019). Although this expanding body of research is insightful, social equity has not garnered as much scholarly attention as efficiency and effectiveness and is the focus of a small proportion of publications in leading public administration academic journals (Gooden 2015; McDonald III, Hall, O’Flynn, and van Thiel 2022). The state of research in this area highlights the need for more scholarly attention to the many debates and questions surrounding diversity, equity, and inclusion (Guy and Williams 2023; Hewins-Maroney and Williams 2007). Despite the importance of social equity as a mechanism to enhance public programs, scholars explore social equity using different theoretical approaches and methodologies (McDonald III et al. 2022).

The earliest applications in the literature were concerned with the design and architecture of the state. These macro-level inquiries focused on the legal and regulatory requirements of the Civil Rights Act, Affirmative Action, and the Equal Employment Opportunity Commission (see Kellough 2006; Sabharwal, Levine, and D’Agostino 2018). By the 1990s, virtually all organizations were grappling with the diversification

of the workforce and visibility of minoritized groups in public service because of these prior legal decisions and expansion of rights. As such, *the organization* emerged as the key unit of analysis for questions of equity because they exhibit discretion and control over how to manage issues of social equity.

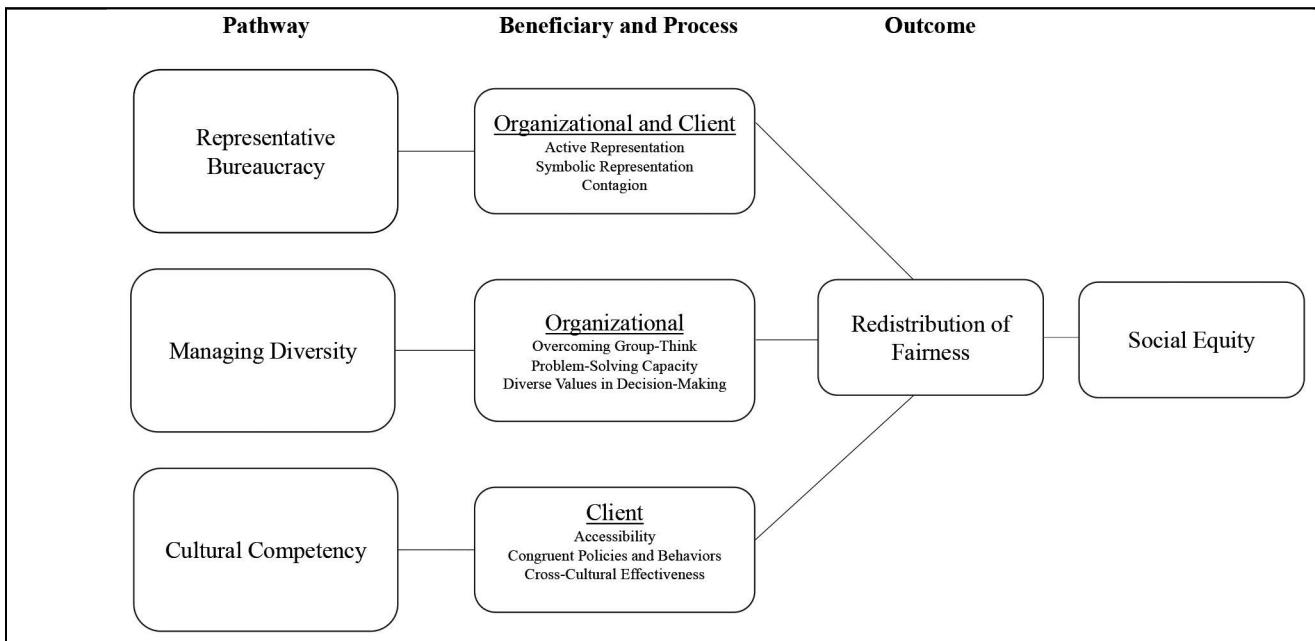
Social equity scholars generally focus on representative bureaucracy, managing diversity, and cultural competency which can be broadly understood as three manipulable and manageable pathways through which fairness can be more equitably distributed within organizations (see Guy and McCandless 2012). Since a social equity lens recognizes how institutions create and reinforce disparities, fairness is an important concept insofar as achieving social equity is concerned because it provides disadvantaged populations (both in terms of bureaucrats and clients) more access to career development opportunities, equal treatment, and improved policy outcomes (see Guy and McCandless 2012; Johnson and Svava 2011; McCandless 2021). All three mechanisms and their purported outcomes are briefly summarized in Figure 1 and discussed in detail in the following sections. Representative bureaucracy distributes fairness by enfranchising minoritized clients and changing majority-group bureaucratic behavior. Managing diversity distributes fairness to bureaucratic actors by enfranchising minoritized viewpoints in decision-making. Finally, cultural competency distributes fairness by providing

clients with effective cross-cultural service delivery. Together, each mechanism serves as a distinct pathway to social equity.

Representative Bureaucracy and Social Equity

The theory of representative bureaucracy is concerned with how the demographic composition of bureaucracy affects the structure, implementation, outcomes, and legitimacy of public programs (Meier 1993). The earliest applications of representative bureaucracy were concerned with the translation from passive to active representation. Mosher’s (1982) work describes passive representation as congruence between the racial, ethnic, or gender makeup of the bureaucracy and the population, while active representation occurs when the actions of a bureaucrat promote the interests of members of the public with whom they share characteristics. Benefits of active representation include reducing outcome disparities and improving the performance of marginalized groups (Atkins and Wilkins 2013; Capers and Smith 2021; Kennedy, Bishu, and Heckler 2020). These benefits result from shared characteristics between bureaucrats and their clients—thus increasing the possibility of active representation whereby the interests of representative clientele are considered during the bureaucratic decision-making process. With a more representative organization, underrepresented and historically marginalized clients can receive better equal

Figure 1. Pathways to Social Equity



access to quality service and equal treatment which contribute to improved policy outcomes and social equity.

Another mechanism, symbolic representation, contends that individuals perceive the bureaucracy as more legitimate, representative, and effective when bureaucracies, and the bureaucrats within, look like them (Ricucci, van Ryzin, and Lavena 2014; Theobald and Haider-Markel 2009). This pathway argues that the presence of representative bureaucracy can change perceptions of bureaucracy and increase trust, which then leads to a greater willingness to engage in coproduction, irrespective of the behavior taken by the bureaucrat. Rather, the mere presence of passive representation can result in attitudinal or behavioral changes in the client which are conducive to better outcomes.

A final, more recent development is contagion or spillover effects. Instead of focusing on how the discretionary actions from minoritized bureaucratic groups affect minoritized clients, the contagion argument focuses on changing majority bureaucratic behavior. In this sense, the primary benefits are organizational—whereby design and implementation are more equitable. While traditional applications of representation treat the process as a corrective mechanism to existing bias perpetrated by majority-group bureaucrats, contagion focuses on behavioral changes among majority-group bureaucrats. Specifically, the theory contends that when majority-group bureaucrats work alongside minority-group bureaucrats, this can facilitate a process of learning and socialization whereby bureaucrats from the majority group engage in more equitable behavior (Atkins and Wilkins 2013; Li 2021; Meier and McCrea 2022). This pathway pushes against the implicit assumption that minoritized groups bear the burden of reforming institutions instead of groups with preexisting power who generated the inequities in the first place (Kennedy, Bishu, and Heckler 2020).

These logics provide a rationale for greater recruitment and retention of bureaucrats from underserved, underrepresented, and disadvantaged communities (Ricucci and Van Ryzin 2017). From a social equity perspective, attention to this type of process can make public programs more effective and equitable by translating the needs and desires of underrepresented groups into policy outcomes, socializing bureaucrats on different values, and increasing the public's perceptions of legitimacy.

Diversity and Social Equity

Treatments of diversity within the United States have historically focused on issues of recruitment and re-

ention due to the legal requirements outlined by Affirmative Action, the Civil Rights Act, and the Equal Employment Opportunity Commission. As this led to a more diverse cross-section of society, the literature shifted to the idea of “managing diversity” within increasingly heterogeneous work groups (Sabharwal, Levine, and D’Agostino 2018). This ushered in the business case for diversity, a human resource management idea defined as “the process of creating and maintaining an environment that naturally enables all participants to contribute to their full potential in focused pursuit of organizational objectives” (Thomas 1990, 112).

Managing diversity often requires a three-pronged approach of recruiting and retaining diverse personnel, valuing differences between groups, and implementing policies and programs that are adaptable to individuals with differing values (Pitts 2006). When successful, diversity can be incredibly valuable within leadership and group decision-making. Diversity can help facilitate a process where everyone’s preferences and values are brought to the table (Page 2017), help organizations overcome “groupthink” (Kelman, Sanders, and Pandit 2016), and improve a number of key indicators such as employee satisfaction and organizational performance (Choi 2013; Pitts 2009; Vanderschuere and Birdsall 2019). It should be acknowledged, however, that diversity is a process that is actively *managed*, meaning that organizations can fail to channel diversity toward effective ends. Past work finds that diversity can create group conflict which offsets the purported benefits of problem-solving capacity, improved organizational performance, and inclusion (see Bendick, Egan, and Lanier 2010; Sabharwal 2014). Nonetheless, demographic shifts and diversification in the public workforce are an empirical reality (Frey 2020). Explicitly studying diversity is essential to identify how diverse organizations are, how effective they manage their diversity, and how diversity affects equitable structures, processes, and outcomes. Such pursuits are consistent with the normative and public values that define a social equity lens.

Cultural Competency and Social Equity

Cultural competency is a broad and encompassing philosophy that recognizes the unique needs and challenges of different socio-demographic groups in society (Rice 2007). Rather than focusing on identity congruence, such as that explored in representative bureaucracy, cultural competency is “a set of congruent behaviors, attitudes, and policies that come together in a system,

agency, and among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross et al. 1989, 13). Cultural competency seeks to end inequities in service outcomes by equipping employees with the skills to effectively manage any cultural mismatch with their clients (Bailey 2015).

Examples of cultural competency can range from providing translation services to accessibility provisions (Norman-Major and Gooden 2012). For example, the California Emergency Management Agency provides earthquake preparedness information in Spanish, Korean, Mandarin, Vietnamese, Lao, Cambodian, and Hmong to better reflect and serve the diverse cultures present within the state (Edwards 2012). Moreover, healthcare providers engage in cultural competency with LGBTQ clients by providing more robust marital status options such as “living with a domestic partner,” allowing for trans individuals to select a gender identity more congruent with their lived experiences and asking open-ended questions that do not adhere to a heteronormative paradigm (Swan, French, and Norman-Major 2012). Cultural competency can also be programmatic through the establishment of community advisory boards designed to learn about specific community needs or the creation of community centers that provide services and promote government partnerships relevant to the needs of specific, underserved communities (Benavides 2012). While each example varies in scope, they are all aimed at fostering behaviors, attitudes, and/or policies that enable an organization to operate effectively across cultural situations. The emphasis is not necessarily placed on the composition of personnel and its link to equity, but rather on how organizational structure, policy, and culture link to equity.

Despite some progress, cultural competency is still systematically underexplored within public administration (but see Gooden and Norman-Major 2012; Rice 2007). In contrast, fields such as healthcare and social work explicitly incorporate cultural competency into practice and offer guidelines and standards on their structure and implementation (Berry-James 2012). What has come out of these efforts is greater attention to the social, environmental, and clinical processes that create disparities and can be addressed through cultural competency practices.

A Descriptive Analysis of Social Equity Practices Within Florida Nursing Homes

Our descriptive analysis relies on data from the Florida

Agency for Healthcare Administration which provides a cross-sectional snapshot of all Florida nursing homes and includes information on their top managers, board members, services provided, and other organizational practices. Additional data from Brown University’s LTCFocus dataset provides demographic information on nursing home residents. Data from CMS Nursing Home Care Compare provides measures on organizational performance. Our sample consists of over 600 nursing home facilities and all data are from 2022.

Similar to other health and human service contexts (see Merritt 2019; Su 2017; Varkey 2022), nursing homes exhibit a high degree of publicness (see Bozeman 1987). Despite the presence of public, nonprofit, and private nursing homes in the market, most services are financed through government programs such as Medicaid or Medicare (Kaiser Family Foundation 2017), with reimbursement directly tied to compliance with federal and state regulations (Amirkhanyan et al. 2019). The presence of these political, regulatory, and financial factors means that nursing homes cannot be considered *purely private* despite their legal ownership suggesting otherwise (see Andrews, Boyne, and Walker 2011; Heinrich and Fournier 2004). Rather, due to nursing homes’ important role in creating public value in society (e.g., caring for the elderly), political and regulatory authorities deem these organizations as public in function and practice. While social equity is not explicitly considered in CMS’s regulatory regime, minoritized populations are concentrated in homes with deficiencies and poorer quality overall (see Amirkhanyan et al. 2019). As such, nursing homes are a highly visible and public context ripe for study that takes an explicit social equity lens.

Studying equity within the Florida nursing home context is salient due to recent attacks from Governor Ron DeSantis on the practice of diversity, equity, and inclusion (DEI) within public universities. Talented, social equity-minded administrators and nurses are the lifeblood of nursing home care, yet efforts taken under the recently signed Florida Senate Bill 266 greatly compromise the ability of nursing homes to provide more equitable care and services. Indeed, such a law sends “a signal that students of color are not welcome in Florida colleges and universities, and that they would not have access to courses that represent them and the complex health needs of the communities they serve” (National Nurses United 2023). Moreover, “it would also provide a devastating blow to our ability to provide an educational curriculum that addresses the health crises created by ongoing racial, gender, ethnic, and LGBTQ discrim-

ination that we experience daily in health care, for our patients and for nurses and other health care workers” (National Nurses United 2023). Such laws can send “chilling effects” whereby public institutions, out of fear of retaliation, do not engage in social equity practices.

Disparities in Nursing Home Care and the Need for Social Equity

Social equity is premised on the reality that systemic bias, mistreatment, and inequity are perpetuated through bureaucratic structures. As such, we use data from CMS and LTCFocus which report performance and resident health data across several key indicators. Our performance measures include the number of health deficiencies and 5-star nursing home rating. Health deficiencies are one of the most common performance measures (Amirkhanyan, Kim, and Lambright 2008). Nursing homes are inspected every 9–15 months and are assessed across 180 different areas including quality of care, resident behavior, and facility practices. Since 2008, CMS has reported a 5-star rating system which is based on a formula that includes 1) a 5-star health inspection rating which includes the last three years of inspections with the most weight placed on the most recent inspection; 2) 5-star staff ratings adjusted by resident needs; and 3) 5-star quality ratings based on patient clinical data. Besides performance, disparities are reflected through human resources. CMS reports information on the RN-to-total nurse ratio. Focusing on RNs is particularly important because they are the most effective nursing personnel (see McCrea 2022), but find better pay and working conditions in hospitals which makes their

presence incredibly valuable (Harrington and Swan 2003; Keenan 2003). Finally, we include a resident acuity index from LTCFocus.¹

Table 1 shows a series of correlations between resident demographics, performance, and resident health. We find that the percentage of women residents and the percentage of white residents are negatively correlated with the number of health deficiencies and positively correlated with the overall 5-star rating. The percentage of Black residents and the percentage of Hispanic residents are both uncorrelated with the number of health deficiencies. The percentage of Black residents and 5-star rating shows a slight negative correlation, but there is no correlation between the percentage of Hispanic residents and the 5-star rating.

Next, we examine correlates for residents’ health quality. The acuity index has no correlation with the percentage of women, a positive correlation for both percentage of Black and percentage of Hispanic residents, and a negative correlation with the percentage of White residents. Overall, these correlations suggest that homes with higher percentages of White residents tend to be healthier than homes with greater percentages of Black and Hispanic residents.

Finally, we examine the correlations between demographic categories and nurse staffing. Significant correlations for the percentage of women residents include a positive association with a positive correlation with the RN-to-total nurse ratio (0.18). For Black residents, we find a negative correlation with the RN-to-total nurse ratio (–0.14). Correlations for the percentage of Hispanic residents suggest

Table 1. Performance by Resident Demographics

	Deficiencies	5-Star Rating	Acuity Index	RN/Nurse Ratio
% Women Residents	–0.21***	0.22***	0.06	0.18***
% Black Residents	0.02	–0.07*	0.14***	–0.14***
% Hispanic Residents	0.06	0.04	0.30***	0.39***
% White Residents	–0.18***	0.12**	–0.25***	–0.08*

Note: Pairwise correlations; *** p < .00, ** p < .05, * p < .1.

1. The acuity index is a summated scale comprised of the following three indices adlindex + stindex + addindex. The adlindex equals (# of eating-dependent residents x 3) + (# of eating-assisted residents x 2) + (# of eating-independent residents) + (# of toileting-dependent residents x 5) + (# of toileting-assisted residents x 3) + (# of toileting-independent residents) + (# of transfer-dependent residents x 5) + (# of transfer-assisted residents x 3) + (# of transfer-independent residents) + (# of bedfast residents x 5) + (# of chairbound residents x 3) + (# of ambulatory residents) divided by (total # of residents); stindex equals (# of residents receiving respiratory care) + (# of residents receiving suctioning) + (# of residents receiving IV therapy) + (# of residents receiving tracheostomy care) divided by (total # of residents); and addindex equals (# of residents with dementia) + (# of residents with psychiatric diagnosis) + (# of residents with intellectual disabilities) + (# of residents receiving PT, OT, or speech therapy) + (# of residents receiving tube feedings) divided by (total # of residents).

Table 2. Representation and Diversity in Florida Nursing Homes

	N	Mean	Std. Dev.	Min	Max
<u>Demographic Characteristics</u>					
Female CEO	638	.57 (57%)		0	1
White CEO	479	.71 (76%)		0	1
Black CEO	479	.18 (18%)		0	1
Hispanic CEO	479	.09 (9%)		0	1
Asian CEO	479	.02 (2%)		0	1
Female CFO	612	.44 (44%)		0	1
White CFO	390	.72 (72%)		0	1
Black CFO	390	.13 (13%)			
Hispanic CFO	390	.11 (11%)			
Asian CFO	390	.01 (1%)			
% Female Board Members	655	.35 (35%)	.2680467	0	1
% White Board Members	655	.59 (59%)	.2306454	0	1
% Black Board Members	655	.07 (7%)	.0375114	0	.5
% Hispanic Board Members	655	.04 (4%)	.1135064	0	1
% Asian Board Members	655	.01 (1%)	.0318418	0	.5
<u>Measures of Passive Representation</u>					
Female Representation	602	.58	.51	0	5.61
Black Representation	461	.46	1.13	0	7.22
Hispanic Representation	263	.38	1.20	0	9.39
White Representation	445	.94	1.25	0	22.3
<u>Measures of Heterogeneity</u>					
Board Racial Diversity	655	.53	.29	0	1

that staffing is better for this demographic group as there is a positive RN-to-total nurse correlation (0.40). Finally, the percentage of White residents is weakly negatively correlated with the RN-to-total nurse ratio (-0.08).

Representation and Diversity in Nursing Home Decision-Making

The Florida Agency for Healthcare Administration (AHCA) reports the name of each nursing home's Chief Administrative Officer (CEO), Chief Financial Officer (CFO), and board of directors. Such rich information on the key decision-makers within nursing homes provides an opportunity to construct measures of managerial representation and diversity. The dataset includes approximately 3,000 nursing home administrators which were coded by race and gender. Our coding strategy included

web searches of publicly available LinkedIn profiles, Facebook pages, nursing home sites, and news articles.²

We constructed the percentage of CEO, CFO, and board members across racial and gender categories, race- and gender-specific measures of representation, and a measure of racial diversity.

Table 2 reports that 57% of homes have a woman CEO. In terms of the racial composition of CEOs, 71% are White, 9% are Hispanic, 18% are Black, and 2% are Asian. Moving to the distribution of CFOs, 44% are women, 72% are White, 11% are Hispanic, 13% are Black, and 1% are Asian. The average nursing home board is comprised of 35% women, 59% White, 4% Hispanic, 7% Black, and 1% Asian.

Next, we look not just at the overall size of groups but how representative they are of the nursing home resident

2. This method is imperfect and relies on the administrator having an online presence and a headshot. While algorithmic techniques would be a more efficient option, our efforts performing this procedure revealed staggeringly high error rates when coding the names of minority administrators. Moreover, relying on a visual coding of race and gender presents its own issues with measurement error since visual cues are not always a clear indicator of one's self-expressed identity.

base. We construct a representation ratio that captures how closely the demographic composition of the nursing home board mirrors the demographic composition of the nursing home residents (see Selden 1997). The demographic composition of the nursing home residents comes from LTCFocus. These data report the percentage of women, White, Black, and Hispanic nursing home residents. The ratio is constructed by taking the percentage of nursing home board members divided by the percentage of nursing home residents. For example, the representation ratio for the Black population would be % Black board members / % Black residents. By construction, a value of 1.0 equals perfect parity between group members. We find considerable underrepresentation across all groups other than Whites, which have a representation ratio of .94—a near perfect parity. In the average nursing home, women’s representation is 0.58, Black representation is 0.46, and Hispanic representation is 0.37.

The diversity index is a measure of heterogeneity among board members. We created a simple Blau index calculated as $1 - \sum p_i^2 \cdot 100$, where p_i represents the percentage of each unique racial/ethnic group—White, Black, Asian, and Latino, respectively. By construction, each nursing home has a calculated value for board diversity expressed in the following way: $1 - (\% \text{ White Board Member})^2 + (\% \text{ Black Board Member})^2 + (\% \text{ Asian Board Member})^2 + (\% \text{ Latino Board Member})^2$. Higher values indicate more diversity across racial categories. The average nursing home has a Blau index of 0.53, which indicates modest levels of diversity within top-level decision-making processes.

Cultural Competency Practices in Nursing Home Care

Language serves as a major barrier in effective care, and this is perhaps most pronounced in an organizational setting that is high touch, low tech, and deals with vulnerable and dependent clientele such as nursing homes. In practice, cultural competency can manifest through simple interventions such as providing material and informational brochures in multiple languages to more costly interventions such as translation and interpretation services (Benavides 2012). The former can promote cultural competency by sending a signal that the organization acknowledges language as a barrier to effective service delivery and a recognition of community

members that speak the language. The latter can promote cultural competency by showing responsiveness and understanding. In short, if a home is advertising the languages spoken within a home, it is likely sending a signal to prospective clients on how different languages and worldviews are valued within the organizational culture and among the members of the organization.

HIV services can be considered a dimension of cultural competency due to the stigma associated with HIV and certain vulnerable populations, such as individuals who injected drugs and men who have sex with men (Emlet 2006; Jin et al. 2013). Experiencing stigma around HIV-status is associated with low social support, poor physical health, and poor mental health (Logie and Gadalla 2009). When organizations harbor stereotypes against HIV-positive individuals, it can compromise effective care (Jin et al. 2013). Federal and state regulations are designed to accommodate residents, including but limited to HIV services. At the federal level, §483.10(a) Resident Rights details that residents can express the type of care and services they need.³ Moreover, nursing homes must provide quality of care regardless of diagnosis. At the state level, the Resident Assessment and Care Plan – 59A-4.109 Section 2 states, “The nursing home licensee [should] develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.”⁴ In this sense, structures are in place to ensure access to care and culturally competent care is extended to this vulnerable population.

However, the reality is that HIV-positive residents often cluster within poor-performing and underresourced nursing homes (Meyers et al. 2019). Despite a legal requirement to provide care consistent with the medical needs of admitted residents, there is considerable variation in the provision of HIV-related services across facilities (Pearson and Hueston 2004). While HIV service provision is a structural step toward cultural competency that validates and accepts a lived experience, *good-performing homes generally do not admit HIV-positive residents* (see Pearson and Hueston 2004). This may suggest cream skimming behavior where good performers select healthier, more financially desirable, and less socially stigmatized residents. As such, *an inability to provide these services* is more interesting

3. <https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf>

4. https://www.flrules.org/Gateway/View_notice.asp?id=16859102

insofar as cultural competency and social equity are concerned because sensitive, vulnerable, and stigmatized clients are deprived access to the types of organizations best equipped to effectively deliver services.

Table 3 presents the different dimensions of cultural competency reported by the Florida Agency for Healthcare Administration. On average, homes practice three languages in addition to English (Mean – 3.36). The highest practiced language, unsurprisingly, is Spanish—which is spoken in 97% of homes. Next is Haitian Creole, which is practiced in nearly 70% of homes and then Filipino, which is spoken in 60% of homes. These are the largest minority groups within the state of Florida and the wide practice of their languages may be indicative of homes trying to tailor services to their population (Amirkhanyan et al. 2019). It also suggests that Florida nursing homes may be culturally competent insofar as language accessibility is concerned. The next highest reported language is French which is spoken in 44% of homes. Following French, American Sign Language is reported in 19% of homes. Insofar as social equity practices are concerned, the low percentage of homes reporting ASL is troubling, since it shifts the responsibility for interpretation services onto the resident and any respective family. The remaining languages are German (19%), Italian (15%), Polish (12%), and Hebrew (8%).

Table 3. Cultural Competency Practices in Florida Nursing Homes

	Mean	Std. Dev.
Number of Languages	3.36	1.71
<i>Specific Languages</i>		
Spanish	0.97 (97%)	
Haitian Creole	0.69 (69%)	
Filipino	0.60 (60%)	
French	0.44 (44%)	
American Sign Language	0.19 (19%)	
German	0.19 (19%)	
Italian	0.15 (15%)	
Polish	0.12 (12%)	
Hebrew	0.08 (8%)	
<i>Service Provision</i>		
HIV Services	0.66 (66%)	

Our data suggests that 66% of nursing homes provide HIV services within their facility. Since there is a link between HIV services and poor performance, Table 4 examines performance and human capital differences by a home's HIV service status. Nursing homes that provide HIV treatment have 1.25 more deficiencies and are rated approximately a 0.5 star lower. Homes that provide HIV services have a 3-percentage point lower RN-to-total nurse ratio than those homes that do not. At face value, providing HIV services should be considered a positive step toward cultural competency. However, the evidence presented here suggests that HIV-positive residents are filtered into homes where effective care is compromised.

Table 4. Performance by HIV Status

	Deficiencies	5-Star Rating	RN/ Nurse Ratio
No HIV Services	4.78	3.47	0.20
HIV Services	6.03	2.97	0.17
Difference	1.25***	3.11****	0.03***

*** p<.00, ** p<.05, * p<.1

Social Equity across the For-Profit and Not-for-Profit Sectors

Long-term care spans sectoral boundaries. Different ownership structures can be reflective of divergent values, priorities, and environmental constraints (e.g. Bullock, Stritch, and Rainey 2015; Johansen and Zhu 2014; Lee and Wilkins 2011). Social equity practices can be part of these differences. Unlike for-profit organizations, social equity within not-for-profit organizations is often pursued due to a greater emphasis on values such as legitimacy, social justice, nondiscrimination, and democracy (Boyne, Poole, and Jenkins 1999; Groeneveld and Verbeek 2012). Indeed, research shows that managers within nonprofit organizations prioritize diversity (Johansen and Zhu 2014), and emphasize quality by investing in the physical environment, equipment, and resident services. Meanwhile, a small number of public nursing homes adopt the role of a social safety net while also emphasizing dimen-

5. Only 13 (1.98%) nursing homes are public which prevents us from deriving any meaningful estimates on the public sector. Since this is the case, we pool the public and nonprofit nursing homes together. This empirical choice is defensible since the distinction in profit motive between the public and nonprofit sectors versus the private sector is a salient cleavage in nursing home care, financial investments, and disparities.

Table 5. Levels of Representation and Diversity in For-Profit and Not-For-Profit Homes

	Women Representation	White Representation	Black Representation	Hispanic Representation	Racial Diversity
Not-for-Profit	0.68 (N = 164)	0.97 (N = 172)	0.43 (N = 103)	0.29 (N = 74)	0.51 (N = 172)
For-Profit	0.55 (N = 438)	0.93 (N = 434)	0.47 (N = 358)	0.42 (N = 189)	0.54 (N = 440)
Significance	P = 0.01	P = 0.67	P = 0.72	P = 0.42	P = 0.00

sions of quality. In both cases, the prioritization of care may provide a pathway through which social equity is disproportionately emphasized and practiced within these sectors.

For-profit facilities are pejoratively referred to as “Medicaid mills” and serve poorer and less informed patients while diverting resources away from core services (Amirkhanyan, Kim, and Lambright 2008). Moreover, research finds that they are less responsive to demand when considering diversity programs (McCrea, Zhu, and Johansen 2022). Additionally, literature on representative bureaucracy finds that private organizations devalue issues of race and gender, which prevents active representation from occurring in that sector (see Johnston and Holt 2021; Roch and Pitts 2012). Taken together, the distinction between ownership status is likely a useful lens for further clarifying and understanding the state of social equity practices.

Table 5 examines differences in levels of representation across the for-profit and not-for-profit sectors.⁵ Women’s representation in the for-profit sector is 0.55 compared to 0.68 among not-for-profit homes. This 13-percentage point difference is statistically significant. For levels of White, Black, and Hispanic representation, we find no significant differences in levels of representation. With that said, we find evidence of White

representation regardless of sector and endemic underrepresentation in the representation of both Blacks and Hispanics.

Next, we look at demographic differences in CEO and CFO leadership in Table 6. In general, we find some statistically significant differences with several exceptions. For instance, 80% of CFOs in the not-for-profit sectors are White while 68% are White in the for-profit sector. There are also more Black and Hispanic CFOs in the for-profit sector than not-for-profit sectors.

Our final analysis in Table 7 is concerned with the differences in cultural competency practices within for-profit and not-for-profit homes. We find no differences in the number of languages practiced across sectors. However, we do observe a 14-percentage point difference in the provision of HIV services. Exactly 74% of for-profit homes provide HIV services compared to only 50% of not-for-profit services. This provides further evidence for the argument that cultural competency is hampered due to the prevalence of HIV service delivery being clustered within for-profit, low-performing facilities. This finding is concerning due to the purported normative commitments that not-for-profit organizations have to serve vulnerable populations.

Table 6. Demographic Composition of Nursing Leaders in For-Profit and Not-for-Profit Homes

	Woman		White		Black		Hispanic		Asian	
	CEO	CFO	CEO	CFO	CEO	CFO	CEO	CFO	CEO	CFO
Not-for-Profit	0.61 (N = 169)	0.48 (N = 158)	0.76 (N = 133)	0.80 (N = 111)	0.15 (N = 133)	0.09 (N = 111)	0.08 (N = 133)	0.08 (N = 111)	0.02 (N = 133)	0.03 (N = 111)
For-Profit	0.55 (N = 426)	0.43 (N = 414)	0.70 (N = 318)	0.68 (N = 270)	0.19 (N = 318)	0.15 (N = 270)	0.08 (N = 318)	0.14 (N = 270)	0.02 (N = 318)	0.01 (N = 270)
Significance	P = 0.18	P = 0.25	P = 0.20	P = 0.01	P = 0.28	P = 0.07	P = 0.45	P = 0.09	P = 0.81	P = 0.47

Table 7. Cultural Competency Practices in For-Profit and Not-for-Profit Homes

	# Languages	HIV Services
Not-for-Profit	3.32 (N = 172)	0.50 (N = 194)
For-Profit	3.49 (N = 440)	0.74 (N = 464)
Significance	P = 0.25	P = 0.00

Discussion and Conclusion

Consistent with the main utility of descriptive analysis (see Gerring 2012; King, Keohane, and Verba 1994), this social equity audit provides a snapshot of the current state of Florida nursing homes and a chance to take stock on what is at stake in a state largely hostile to DEI efforts. First, we find that the percentage of White and women residents is correlated with better performance (no relationship for Black and Hispanic residents). At the same time, we find that Black and Hispanic residents are generally unhealthier, but, in the case of homes with a large Black population, this does not translate into better human resource practices to tend to this higher level of resident need.

Second, we find that the distribution of minority CEOs and CFOs is relatively close to their size within the state's population (America Counts Staff 2021). However, this representativeness does not extend to the nursing home board—raising the possibility of tokenism at the executive level and a narrow set of values reflected in decision-making. Third, we find that, on average, nursing home boards are unrepresentative (descriptively) of women, Black, and Hispanic residents. This suggests that long-term care options for these populations may be limited if questions of representativeness are of concern to prospective residents and their families.

Fourth, the results from the cultural competency audit are mixed. On the one hand, the average nursing home provides services in three different languages which indicates significant human resource effort and organizational cultures which tailor services to diverse worldviews. However, only two-thirds of homes provide HIV services, and these homes tend to be of lower performance and human resource quality. This finding is troubling as it suggests that organizations with the capability to serve residents with special needs may be strategically avoiding admission, leaving residents with

suboptimal choices in the market. As such, *who is not* providing culturally competent care is more important than *who is*.

Fifth, we find some evidence of sectoral differences. There are considerably higher levels of women's representation in the not-for-profit sector, but little evidence of differences in racial representation. There are, however, higher levels of racial diversity and more minority executive leadership in the for-profit sector. Finally, HIV services are predominantly clustered within the for-profit sector which are the lowest-performing homes. These findings are concerning as they suggest that the purported sector leaders in social equity are acting in ways inconsistent with that goal.

Taken together, these findings demonstrate that Florida nursing homes are moving the needle closer to social equity on some dimensions more than on others. Unfortunately, much of this progress is at stake due to Florida's political landscape and larger issues with human resource management that can shut off these pathways to social equity.

It is of paramount importance for nursing home administrators to inject more diversity into board decision-making. One of the great shortcomings revealed by this audit is the poor performance, greater health needs, and lower human resource quality in homes with larger proportions of minority residents. As executive decision-making is responsible for strategic human resource management, increasing diversity and representation within nursing home boards can facilitate a greater commitment to hiring better personnel by both sending a signal to prospective nurses on what the home values out of their nursing staff and infusing additional equity considerations into strategic hiring decisions. In short, it is the anchor that makes a redistribution of access, resources, and fairness possible. Unfortunately, these efforts stand against the structural challenges of lower pay, harder working conditions, and lax staff regulations that steer high-quality nurses away from nursing home care (see Harrington and Swan 2003; Keenan 2003). Amplifying these challenges are the very public and political attacks against DEI practices by the DeSantis administration. Such hostility can hinder efforts at recruiting out-of-state minority nursing home administrators, alienate and push out current minority nursing home administrators, and halt any current efforts undertaken by nursing home administrators to pursue social equity.

The other issue is the need for better-performing and not-for-profit homes to expand services to residents with HIV. As treatment for HIV continues to become more accessible, those living with the disease are living longer, which increases the demand for long-term care. As such, more homes need to distribute this responsibility, admit these patients, and provide culturally competent care that affirms this historically marginalized and stigmatized group. To our knowledge, the sectoral gaps identified in this article are novel and push against classic contentions of not-for-profit organizations as the drivers of social equity. Our analysis reveals that the organizations most equipped to handle this population are not living up to their standard and allow these individuals to be filtered into private organizations concerned with profit maximization and efficiency of service over effective, equitable delivery.

While specific strategies toward achieving greater social equity are beyond the scope of this article and require an intentional research design that unveils what works and doesn't work, the results from this social equity audit are clear—Florida nursing homes struggle with social equity and whatever progress made is at a critical juncture. This audit serves as an alarm to social equity scholars and practitioners on what is at stake and hopefully generates attention and discussion to these issues within nursing home care and elsewhere.

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