

# Diversity in Multi-Institutional Settings

**D**iversity has become a vital concern to the Catholic health ministry. In view of that fact, Health Progress is publishing a series of interviews with people who have undertaken significant leadership roles in fostering diversity in their organizations and communities.

This interview was conducted by Sr. Karin Dufault, SP, RN, PhD, vice president, mission leadership, Providence Health System, Seattle. Sr. Karin's conversation was with Chris Carney, president and CEO, Bon Secours Health System, Marriottsville, MD. Everard O. "Rod" Rutledge, Bon Secours' vice president, community commitment, who conducts most of this series' interviews, was a participant in this one. Sr. Teresa Stanley, CCVI, PhD, CHA's senior director, sponsor services, participated as well.

**Sr. Karin:** As you know, we are publishing a series of articles related to diversity. The focus for our interview with you is promoting diversity in mostly institutional settings. Would you describe the Bon Secours Health System?

**Carney:** Bon Secours Health System, Incorporated, (BSHSI) is sponsored by the Sisters of Bon Secours. We are a multistate, diversified ministry. We deliver a variety of services in nine states, all in the eastern United States. We are very much a community-based health care provider, as opposed to one based on a university health center, and there is great diversity in the communities we serve. We serve some areas that are quite rural and remote from major metropolitan areas. We also serve a number of suburban communities, with varying degrees of economic status, and we serve some very densely populated urban communities, with great variation in their socio-



Sr. Karin

demographics. So the topic of diversity is really critical, and relevant to us for a number of reasons, including the great diversity of the populations we serve and the changing nature of our employee population.

**Sr. Karin:** Would you like to go into that a little bit further?

**Carney:** Diversity reflects the values and the operating principles of Bon Secours—of both our sponsors, the Sisters of Bon Secours, and BSHSI itself. The values of respect, integrity, justice, and compassion are highly related to the concept of diversity as we have pursued it. I think that diversity is, in a very pragmatic sense, also helping us to be a better organization, and that diversity will ultimately yield better practices. It will produce better communication and better understanding, and will help to improve the quality of care we provide. These are examples of efforts that Rod Rutledge is leading or coordinating. Diversity will improve communication with our employees—and with suppliers and providers. It's a moral calling for us, but diversity also has a clear, positive impact on the business practices of BSHSI.

**Sr. Karin:** BSHSI is widely recognized for the work it has done on cultural competency and diversity. Can you tell us something about the inspiration behind this work?

**Carney:** Rod and I recently reflected about BSHSI as it was in the late 1990s. At that time, diversity was absent from the system's plans, policies, and procedures—and even from our language and our structures. There was no actual resistance to diversity, but there was, I would say,

an absence of thinking about it.

BSHSI's senior leaders came to believe that, for the reasons I cited above, the situation was unacceptable for our organization. So we formulated a proposal to our board of directors, recommending that diversity become a part of BSHSI's strategic plan. We have pursued that objective in a variety of initiatives, and it is now very much a part of the organization. We would like to see diversity be an even more vibrant element, but we are gratified to see it come as far as it has in recent years.

**Sr. Karin:** *When did your initiative begin?*

**Carney:** In 1997, approximately 12 months after I became the system's CEO.

**Sr. Karin:** *What are some of the successes you have enjoyed since beginning the diversity initiative in 1997?*

**Carney:** Success has come in numerous dimensions, including diversity of thought. Diversity is now reflected in the business processes of the organization and in how we evaluate executive performance. For example, we now hold the executive search firms we use accountable for diversity. In fact, we select executive search firms on the basis of their commitment to diversity and their track record in diversity. We require the firms to submit semiannual reports on the results of the executive searches they have done for BSHSI, outlining candidate portfolios and tracing the candidates' courses as they work their way through our system's interview process. The search firms' success in presenting a comprehensive array of candidates to us is a critical factor in our determination whether to retain them.

Under Rod's leadership, we have made substantial revisions to BSHSI policies related to recruitment, advertising, and material related to patient care. I believe Rod would agree that one of our most important policy changes was implementing a care assignment nondiscrimination policy prohibiting consideration of the race or ethnicity of employees who provide patient care. That was a strong stance that we took systemwide against discrimination, and it was one founded on our values.

We have also encouraged and participated in the diversity initiatives of Premier, the group-purchasing firm of which we are shareholders. And we have communicated to our other business partners our expectations regarding their practices relative to diversity. Again, under Rod's leadership, we have developed a systemwide program of continuing

education, ranging from a fundamental, introductory approach to diversity to more specific advanced courses. Rod would be better prepared to comment on this. We will continue to make diversity a part of the curriculum for BSHSI, helping us to become more advanced in our understanding and implementation of diversity thought and action—in, for example, the cultural competency "tool box" we are going to be using on some of the nursing units and in some of our facilities.

**Rutledge:** BSHSI's diversity plan has nine different elements (see **Box**, p. 42), one of which is care management. With that in mind, we began exploring the differences among the new populations coming into our respective communities and institutions. We saw that we needed to embark upon an educational experience for our employees, primarily those who are in the direct delivery of care. We needed to give them the "tool box" that Chris just mentioned, one that would assist them in understanding the various cultures both ethnically and racially.

In cooperation with our consultant Cook Ross, Inc.,\* we have developed what we call *CultureVision*, an Internet-based instrument that our staff can use to identify ethnic and racial characteristics related to health, death and dying, nutrition, and other topics relevant to the care process. We are just about ready to roll that out.

**Sr. Karin:** *So CultureVision is being tailored to your organization with support from your consultants?*

**Rutledge:** It's being developed in cooperation with the consultants, but we were intimately involved in designing it and in identifying most of the groups included in the instrument.

**Sr. Karin:** *Will CultureVision be something that other organizations could have access to and benefit from using?*

\*Cook Ross, Inc., Silver Spring, MD, ([www.cookross.com](http://www.cookross.com)) specializes in diversity issues.

*Diversity is  
now reflected  
in how we  
evaluate  
executive  
performance.*

—Chris Carney

**Rutledge:** To do that, they would have to make arrangements with Cook Ross, Inc. BSHSI contributed to *CultureVision*, but Cook Ross, Inc., is its owner.

**Carney:** One of the communities we serve is Hudson County, NJ. As I understand it, there are more than 100 different languages or dialects spoken there. Major metropolitan areas—be they Detroit, Chicago, or Dallas—are seeing an influx of populations whose first language is not English. That places on health care providers an obligation to better understand, not just these people's clinical needs, but also their view of the world and the cultural traditions they bring with them. Fortunately, BSHSI has taken a leadership role, working with clinicians to identify ways that we can better serve our changing patient populations.

**Sr. Karin:** *Would you elaborate just a little bit more on BSHSI's policy related to discrimination in patient care.*

**Carney:** The issue was particularly important to me because of my background as a hospital executive. We occasionally had situations in which a patient would request that a caregiver be transferred from that patient because of the employee's race or ethnicity. We felt that this type of request was inappropriate and sent the wrong message to our employees. Under Rod's leadership, with much clinical input, we ultimately developed a policy that prohibits the assignment of caregivers for any reason other than clinical.

**Sr. Karin:** *Does the policy outline a way to handle that delicate issue? Is learning how to handle such requests part of staff education?*

**Rutledge:** Yes, the policy includes steps that engage our mission leaders, along with nursing and physician leaders, in the process.

**Carney:** You can understand that it's important for us, in responding to such requests, to follow the chain of command and chain of communication, so that those who are responsible for the patient care—such as the physician—are not kept out of the loop.

Incidentally, we are also now developing a systemwide procurement policy as part of our supply chain management initiative relative to minority business enterprise and women's business enterprise. This policy will incorporate our diversity commitment in purchasing and in services involved in construction, environmental matters, materials, and others.

In our corporate office, we have a diversity committee that is responsible for diversity plans and initiatives at the corporate level. The diversity committee has done some great things, including revamping monthly staff meetings in a way that encourages dialogue and participation by more members of the staff. The diversity committee now has great influence regarding the meeting agenda and topics. And the meetings' climate has really changed because we have, in effect, turned it over to employees, asking them: "How do you want this meeting to work?"

I think anyone who attends our monthly staff meetings—and many people do, because we invite corporate employees based at local systems to join by phone—experiences an improved climate. This is probably not the most important thing we've done, but my point here is that we have tried to look both

### Elements of the BSHSI Diversity Quality Plan

Nine key elements define the major areas of focus, leverage, and measurement of the system's Diversity Quality Plan.

**Leadership and Management** To establish strong, courageous, and model leadership in diversity and in guiding BSHSI as an inclusive, multicultural organization

**Planning and Strategy** To ensure that planning and implementation of strategic priorities reflect commitment to diversity

**Marketing and Communications** To ensure that BSHSI's internal and external communication strategies are inclusive of the diversity among our employees and communities served

**Care Management** To support the delivery of culturally competent care through care management and community health partnerships

**Employee Staffing and Development** To support those efforts that will facilitate the hiring, promotion, and development of individuals who are reflective of the populations represented therein

**Employee Education** To create and enhance employee educational opportunities that build cultural competency while increasing job skills

**Community Relations** To ensure that community organizations representative of diverse groups are partners regarding outreach and delivery of culturally competent care

**Organizational Culture** To create an organizational culture that is inclusive of differences, where leaders, board members, community members, co-workers, and patients feel free to express their diversity of thought and opinion as a contribution to the betterment of BSHSI

**Procurement of Supplies, Equipment, Services** To enhance economic development and to further BSHSI's community partnership philosophy, BSHSI's procurement practices include minority and women-owned businesses

at big things and at things that are not so big. We wanted to make the effort comprehensive.

**Sr. Karin:** *Do BSHSI's local organizations also have diversity committees?*

**Rutledge:** Yes. At some local systems, diversity activities are handled by an existing committee—the human resources committee, for example. Other systems have a specific diversity task force.

**Sr. Karin:** *You've described the activities of the diversity committee at the corporate level. Are the activities of the groups at the system level comparable?*

**Rutledge:** Yes, our corporate office is considered a local system for the purposes of diversity. That committee looks at the needs, issues, capacities, and challenges related to cultural competency and diversity in that office.

**Sr. Karin:** *Chris, you said that, in one of the communities BSHSI serves, more than 100 different languages are spoken. I would certainly interpret that as a challenge to the deployment of your diversity policy. Would you discuss some of the other challenges you've run into?*

**Carney:** Even with the progress BSHSI has made so far, we still have a lot of work to do. We have emphasized the importance we put on diversity in governance; and we expect local systems, which nominate their own boards, to consider diversity as an important factor. But in some of our service areas, the Caucasian population may be 97 percent or 98 percent of the community total. You have to work particularly hard to identify candidates who are not of the majority and who have the capability and the interest to serve in governance. So, in some sense, even our demographics present a challenge.

I would say that the bigger issue we deal with on a routine basis is helping local system executives and employees to go beyond seeing this as an additional task—as something they do at the end of the day, or something that interferes with their primary work. To the extent that we can integrate diversity into our work lives, it becomes a *natural* part of what we do, rather than something that is out of the ordinary. While I think we have made some progress, I also know that everybody involved in this interview understands how incredibly challenging health care is these days, how extraordinary are the pressures that people face just to deliver clinical services or get accurate

patient bills sent out. So, achieving cultural competency remains a challenge for us.

**Rutledge:** I think that's a fair representation of the situation. We really haven't had any "push back" at all. And I think much of the credit for this goes to how we went about organizing our efforts. We feel that we have employed a novel approach in our training initiatives, which, unlike some types of diversity training, do not put participants on the defensive. Our evaluations have always been, on a five-point scale, in the range of 4.1 to 4.7 or higher.

**Sr. Karin:** *Is there any other information that you would like to share with us about your initiatives?*

**Carney:** We are really very fortunate to have the support of our sponsoring congregation and our board, both of which continue to hold us accountable for the diversity plan. So it's not merely senior leadership going forward, and it's not only the senior staff of the local systems. I suspect that, as they get to know more about the diversity initiative, people will come to understand that it is something supported by—and accompanied by expectations from—the sponsors and board.

**Sr. Karin:** *Does BSHSI have any specific performance objective related to diversity?*

**Carney:** We have performance objectives in the qualitative sense—that is, we expect that certain behaviors will take place as the result of the policies we described earlier. We have not given the executive search firms particular targets to shoot for, but they recognize that if their performance is not up to our expectations we will make them aware of it. The procurement diversity initiative I mentioned will have more quantification to it. So, by and large, yes, there have been written expectations, but their use has been fairly informal so far.

One additional point I'd like to make, before we end this interview, is that many businesses *outside* health care have gone further than we have in committing resources to diversity. We have a lot to learn about diversity practices, and there are non-health care organizations that can help us do it.

**Sr. Karin:** *Are there particular organizations that could help us learn about diversity practices?*

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## THE "SENTINEL EVENTS" STUDY

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### THE MINISTRY SHOULD LEAD

A hospital, skilled nursing facility, or clinic is the last place a person should feel unsafe, let alone fear death because of a medical mistake. Catholic health care organizations should not be "close followers" in efforts to improve patient safety throughout the continuum of care. Rather, the Catholic health ministry should lead, taking the risk and spending the dollars to develop, maintain, and continually improve a health care delivery system that is fundamentally safe for all and does not—as is currently the case—allow 268 patients to die daily because of preventable errors. We may be able to tolerate a 4 percent error rate in the U.S. postal system, but it is just unacceptable in the U.S. health care system. □

### NOTES

1. Institute of Medicine, *To Err Is Human: Building a Safer Health System*, National Academies Press, Washington, DC, 2000. The report recommended a four-tier approach in enhancing hospital safety: (1) Establish a national focus; (2) expect hospitals to have a voluntary reporting system; (3) raise performance standards and expectations; and (4) implement safety systems at the delivery end.
2. Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, National Academies Press, Washington, DC, 2001.
3. "Patient safety" is understood to be an inclusive term applicable across the health care continuum; it is not restricted to acute care settings alone.
4. Charles Perrow, *Normal Accidents: Living with High-Risk Technologies*, Princeton University Press, Princeton, NJ, 1999.
5. James T. Reason, *Managing the Risks of Organizational Accidents*, Ashgate Publishing, Aldershot, England, 1997, p. 25. See also James T. Reason, *Human Error*, Cambridge University Press, New York City, 1990.
6. Reason, *Managing the Risks*, p. 9.
7. Robert Wachter and Kaveh Shojania, *Internal Bleeding: The Truth behind America's Terrifying Epidemic of Medical Mistakes*, Rugged Land, New York City, 2004, pp. 165-167.

## "MERCY MEDS" BOOSTS SAFETY

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use the new technology and processes in a patient care setting and revealed a need for further modifications and improvements. But it also clearly demonstrated Mercy Meds's ability to detect potential medication errors and improve patient safety.

As of October 2004, Mercy Meds was in service to approximately 900 patient beds at seven system facilities. To date, detailed data has been reviewed on more than 90,000 administrations, indicating that Mercy Meds point-of-care technology has prevented 386 potential errors. Because point-of-care technology alerts staff to a potential medication error *before* the medication can be administered, it is helping the system shift from reactive post-event medication reporting to proactive "near-miss" reporting. Near-miss data can be analyzed even further so as to reduce the possibility of future medication events.

Clinical pharmacy services also are beginning to positively affect the medication use process. As of August 2004, more than 50,000 pharmacist encounters had been documented; each of these encounters contributes to improved patient education and safety, cost-effective care, and positive clinical outcomes.

The entire Mercy Meds experience has strengthened the sense of "systemness" at Mercy, through increased interaction among facilities and professional disciplines, especially nursing and pharmacy. Through process redesign and implementation, staff members have gained a greater appreciation and understanding of the value of collaboration and coordination and of the benefits that can be achieved from them. □

### NOTES

1. Institute of Medicine, *To Err Is Human: Building a Safer Health Care System*, National Academies Press, Washington, DC, 2000, p. 2.
2. "Pharmacy-Nursing Shared Vision for Safe Medication Use in Hospitals: Executive Session Summary," *American Journal of Health System Pharmacy*, May 15, 2003, p. 1,046.

## DIVERSITY IN MULTI-INSTITUTIONAL SETTINGS

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**Carney:** I attended a conference on diversity sponsored by the Conference Board.\* It was absolutely wonderful, but I was the only participant from a health care *provider*, which was a little surprising to me. There were participants from pharmaceutical and medical supply companies. An organization like the Conference Board is a great source of information.

**Sr. Teresa:** I think it would be helpful for our members if we could put some of the diversity resources developed by various systems on CHA's website. Could we, for example, put on the site *CultureVision*, the tool developed by BSHSI and Cook Ross? I'm sure that CHA's Diversity Committee could profit from studying it.

**Carney:** BSHSI would be happy to make available any resource within its domain. However, Rod will have to explore any legal ramifications regarding sharing *CultureVision*. But I expect that if *CultureVision* has the merits we think it has, Cook Ross will certainly be interested in getting a broader visibility for it.

**Sr. Karin:** *Chris, I want to thank you and Rod for being willing to share your experiences. We hope that others will be inspired by what you have done and will think more seriously about diversity. Diversity is not yet, I suspect, a top priority for all of our CEOs, but I think it's time for it to become a top priority. We certainly hope that, through this series of articles, we will enhance awareness of the importance of diversity in Catholic health care.*

**Carney:** If CEOs are not committed to diversity personally, it will become even more of a challenge than it is now. □

\*The Conference Board ([www.conference-board.org/](http://www.conference-board.org/)) is a not-for-profit organization that advises businesses on management and market questions.