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# Diversity Is a High Priority at CHI

**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.

The interviews were conducted by Everard O. Rutledge, PhD, FACHE, vice president, community health, Bon Secours Health System, Marriottsville, MD. This, the third interview in the series, was with Kevin E. Lofton, president and CEO, Catholic Health Initiatives, Denver.

**Rutledge:** Please describe Catholic Health Initiatives (CHI) and its efforts toward diversity.

**Lofton:** CHI was founded in 1996, initially by three Catholic health care systems—Franciscan Health System, Aston, PA; Catholic Healthcare Corporation, Omaha; and the Sisters of Charity Health Care System, Cincinnati. Then, in 1997, the Sisters of Charity of Nazareth (Kentucky) Health System joined us.

In 1998 and 1999, CHI began to look at its operating model. Initially, we were founded on a holding-company model, but we experienced a significant financial downturn, which drove us to reexamine many different facets of our organizations. At that point, we began to move toward an operating model.

The relevant point here is that CHI, as a national organization, tried to develop a healthy balance between the decisions made in the national office and those made at the local level. In talking about “diversity” in this interview, I mean diversity as it relates to people on the national CHI payroll. This includes all of our local CEOs (and members of local boards of trustees) but not



Lofton

the managers or staff members below them. We call our local providers “market-based organizations” (MBOs). In general, I will be speaking here about the national organizations, not the MBOs.

Some places have more board diversity than others.

There are CHI facilities in 19 states, including some with rural communities that—quite honestly—don’t really have a diverse population. If a CEO position were to open up in, say, North Dakota, I don’t know that I would try to recruit a minority member to take it. I think the whole rationale for promulgating diversity sometimes begs the question: Does it really fit a particular community? CHI has a number of small, rural communities in Appalachia, North Dakota, South Dakota, and Minnesota where the populations are not very diverse and filling positions is sometimes difficult. In places such as Idaho, Oregon, and the Dakotas, which have many members of the Church of the Latter-Day Saints, we have a number of CEOs who belong to that church. In the upper Midwest, we have a number of Lutheran CEOs, because of the large number of Lutherans in those communities. We believe both in looking at diversity globally and in being realistic about where we may or may not be able to place people.

Here’s a quick overview of CHI. We have 68 acute care hospitals; 44 long-term care, assisted-living, and independent-living units; 6 community health services organizations; 2 free-standing psychiatric hospitals; and 2 free-standing rehabilitation hospitals. Our national headquarters is in Denver; and we have two national offices, in Minneapolis and Erlanger, KY, just south of Cincinnati. We have approximately 67,000 full-

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and part-time employees. This year, our net revenue will be \$6.3 billion. CHI is structured as a public juridic person within the Catholic Church, which means that our Board of Stewardship Trustees, composed of people from all over the country, serves both as CHI's sponsor and its agency of governance. CHI was founded as a lay-religious partnership. The board has 15 members: the CEO, seven laypeople, and seven religious.

**Rutledge:** *Why, when there are so many challenges facing health care today, is diversity so important to CHI?*

**Lofton:** I first interviewed for a position with CHI in 1997. When I met Pat Cahill, who was then the system's CEO, I asked her about diversity. She very quickly said that it was something that fit CHI's core values and that she would be interested in pursuing. But she was very candid in saying that there really was not much diversity in the organization. At that time, if you looked at the board, the CEO group, and the senior leadership team, you saw zero racial diversity. The local boards had some diversity in some locations: The Little Rock, AR, and Chattanooga, TN, facilities each had at least four black board members. Here and there, CHI had a few minorities on the senior management teams of the MBOs. We had one black chief nursing officer in the

whole system; we had no Hispanic chief nursing officers. The starting point was pretty grim.

When I joined CHI in 1998, Pat made the commitment that diversity would become a priority. Pat asked me to start by making a presentation to our board, just to get diversity on the system's radar screen. From there, we began to move forward.

In keeping with our faith-based culture, we have focused the bulk of our attention on our culture. It's one thing to introduce diversity programs; but if the organization isn't ready or the leadership doesn't embrace it, then you're just dropping people into a situation they are unprepared for and won't understand. A lot of our

early efforts were spent on what I call "diversity-and-cultural readiness"—making sure that people understood what we were talking about.

We're not trying to do this as a numbers game. One of CHI's core values is reverence. Reverence includes diversity. And by "diversity," we mean not just ethnic, racial, and gender diversity but also diversity of perspective. In our corporate culture, this can be seen in the "360-degree" assessments of our executives. Among the areas rated are teamwork, collaboration, and seeking out and valuing diverse views. One section rates the executive on whether he or she treats others with respect in all interactions and has developed his or her teams to reflect the diversity of the people we both serve and employ. We also rate executives on the time they spend developing, mentoring, and coaching people. By making these expectations part of executives' performance reviews, we embed them in CHI's culture.

Today CHI has a different look than it did in 1998. For example, the membership of our highest-level executive team, a group of eight people that we call the President's Council, is 25 percent minority and 25 percent female. Our national leadership team is 14 percent minority and 45 percent female. People sometimes say, "Your number of women executives is high because you have a lot of nuns." Of the 22 people on our national leadership team, 10 are women, but only three are women religious.

We still have a long way to go with CEOs at our MBOs. Only 4 percent of them are minority; 21 percent are women. The CHI Board of Stewardship Trustees is 13 percent minority and 60 percent women, including three laywomen.

**Rutledge:** *What part does executive leadership play in facilitating your diversity strategy?*

**Lofton:** It has to start at the top, with both executive and governance leadership. At CHI, we began at the CEO level and the national office level. We've placed as much emphasis on gender diversity as on racial and ethnic diversity.

We've used several different tactics. First, we make it clear to the executive search firms we engage that we want to see diverse slates of qualified candidates. Second, we make it a point to include at least one minority-based search firm in our searches; we believe that such firms may have greater insight in identifying candidates. And, third, we network.

In 2002, at the combined CHA-Catholic Charities USA meeting in Chicago, I was introduced to a young man named Angel Gutierrez, who was then a manager with Catholic Charities in that city. I was very impressed with him and made a note to myself to keep him in mind. Later, our community health service organization in Denver was looking for an executive director. Denver is about 35 percent Hispanic. We contacted Mr. Gutierrez; he went through the search process; and we were successful in hiring him. He's an example of careful networking in which success breeds success.

Organizations like CHI and Catholic Healthcare West, San Francisco, have now attracted minority leaders into their senior management. These leaders, who have their own networks, will be in a position to open the door for others. I knew it would be great if we could recruit a Hispanic executive director for our community health services organization in Denver; diversity is essential in serving the city's Hispanic population. In places like Little Rock, Chattanooga, and Towson, MD, all of which have large African-American populations, we tell the MBO CEO that we expect him or her to work toward diversity. Indeed, that expectation will be part of his or her performance review. To be successful in communities with a diverse population, organizations must have a leadership team that mirrors the population.

Here I want to mention CHI's Executive Diversity Fellowship program, which we launched in 2003. In planning it, we looked at similar programs sponsored by organizations such as the National Association of Health Services Executives (NAHSE) and the Institute for Diversity in Health Management (IFD).<sup>\*</sup> Most internships, fellowships, and residencies are geared toward people who are beginning careers. Our goal was different. We wanted to help people who had already been in the workforce for a few years. And we wanted to promote from within, if possible.

The yearlong program is designed to offer a fellow an exposure to all aspects of our organiza-

tion. He or she spends the first month with me; five months with one of our regional executives; five months at an MBO; and the last month again with me. The program—including salary, travel, and lodging—is funded by the national office. A fellow's salary is market-competitive, based on the level at which he or she was functioning before joining the fellowship program. CHI makes no commitment to hire fellows on completion of the fellowship. But if we think they are people who are worth a continued investment, we will do everything we can to help place them.

In fact, we are now trying to place two recent fellows in permanent CHI positions. While doing so, we have temporarily suspended hiring new fellows because we feel it's vital to place the two we have. Toward that end, we've extended the fellowships of the incumbents. We have assigned both to projects that will provide them with good experience while they "earn their keep."

**Rutledge:** *The ministry's human resources needs are great. How can we attract young, ethnically diverse people to all levels of health care?*

**Lofton:** Well, you have to commit to do it. You must be in a position to attract qualified minorities in every executive search. Our recent hiring of Michael Rowan as CHI's chief operating officer is a perfect example. A search firm presented Michael to us in the first round of a diverse slate of candidates. Michael would not have applied for the CHI job on his own because he was comfortable in his previous position. But the search firm urged him. In my opinion, you pay such firms for two things: First, having an independent agency manage the process ensures objectivity. Second, search firms identify candidates who, left to themselves, might not apply. Since the search firm in this case was directed to produce qualified candidates, we selected an African American because he was the best candidate, not because he was African American. Had we not, early in the process, expressed our expectations concerning a diverse slate of candidates, Michael might not have even been in the pool.

Michael's recruitment is an example of commitment from the system's top level. As for middle management, I go back to the cultural readiness I mentioned earlier. The organization must prepare its leaders to understand what diversity is all about—to understand that it's not a numbers game, that we won't be hiring people who aren't

<sup>\*</sup>Information concerning the National Association of Health Services Executives, Silver Spring, MD, can be found at [www.nahse.org/](http://www.nahse.org/). Information about the Institute for Diversity in Health Management is at [www.diversityconnection.org/](http://www.diversityconnection.org/).

qualified. Qualified people will be successful and will contribute to the organization's success. You must establish the foundation.

I've seen situations in which people resent the person hired because they think it was because of some quota system. I have also seen situations in which a minority member was hired but stayed only a short period of time because he or she felt discriminated against or maybe just not welcome. Whatever the reason, aiming for diversity without changing the culture doesn't work.

Networking can't be overestimated. I look at the number of people I've helped to identify for positions that opened up at CHI. Knowing what positions were vacant and knowing people who were looking to make a move, I was able to get them into the candidate pool. This has resulted in the hiring by CHI of a number of minorities who have done well in our system.

The same concept applies to governance: a board should reflect the community it serves. Take the board of St. Joseph Health Ministries of New Mexico, in Albuquerque. That community is about 45 percent Hispanic. When we began our diversity efforts, the 15-member board had only one Hispanic member. Today it has seven.

Finally, I'd like to urge associations like CHA to affiliate with minority organizations such as NAHSE and the IFD. Here's a case in point. Each year, NAHSE holds what it calls the Everett V. Fox Student Case Competition, in which teams of minority graduate students present a case involving health care management to a panel of experts. The winning team is awarded scholarships. We flew this year's winning team, from Ohio State University, to Denver to make a presentation to our senior management team. As a result of that exposure, we are currently interviewing one team member to see if we can attract him to our organization. Through networking, another has been hired by CHRISTUS Health, Irving, TX.

**Rutledge:** *What other diversity or cultural competency issues does CHI face at this time?*

**Lofton:** For one thing, we comply with Americans with Disability Act regulations concerning the hiring of qualified disabled people. A CHI human resources vice president falls into this category.

Recently our Diversity Committee has said that we need to take up the issue of disparity in health care delivery. This has been an increasingly hot

topic in health care since the Institute of Medicine report (*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academies Press, Washington, DC, 2002). Disparity in care was a topic at an American Hospital Association (AHA) Regional Policy Board meeting that I attended last year and at a national AHA board meeting as well.

You would be surprised to learn how naive the general population is about this issue. Well-meaning people who do not themselves discriminate can be naive about the prevalence of discrimination in health care delivery. That's why CHI is pooling information on disparity to use in educating our leadership. We've added it to our agenda.

On the purchasing side, we've also made progress toward diversity. Before I came to CHI, I was at health care organizations in Birmingham, AL, and Washington, DC. At both places, we required certain amounts of minority business. We often achieved this by encouraging major vendors to partner with minority firms; we've done the same thing at CHI. In addition, Robert Johnson, a former CHI board member, helped us identify several minority firms—including an executive search firm—with which we have established business relationships.

**Rutledge:** *What do you see in the future concerning diversity in Catholic health care?*

**Lofton:** I've been on CHA's Diversity Committee since its inception. We've made a lot of progress. The Catholic health ministry has, I think, made more progress toward diversity than other component of U.S. health care, except for the public sector. But there is more we can do.

I would say that CHI, Bon Secours Health System, and Catholic Healthcare West have made real progress. I recently became a member of the board of Ascension Health, St. Louis, and I hope to help that system reach its diversity goals.

I think CHA could do more to share information across systems. And CHA needs to look at its own employment practices, in terms of leadership at the top. I believe the association has done an excellent job of diversity at the governance level—a direct result of work done by the Diversity Committee. I would give CHA high marks on governance diversity—8 on a scale of 10. But I still think we are behind in terms of hiring at the association. □