Diversity Is a Leadership Responsibility

Trinity Health, Novi, MI, Has Made It a Factor in CEOs' Annual Evaluation

BY JOSEPH R. SWEDISH

Mr. Swedish is president and chief executive officer, Trinity Health, Novi, MI. He was the keynote speaker at a breakfast given by the Institute for Diversity in Healthcare Management, held in New Orleans last March during the American College of Healthcare Executives' Congress on Healthcare Leadership. This article is adapted from his presentation.

Not long ago, I learned of a musician who had to quit working because of a pain in his back so intense that his daughters had to carry him into a hospital's emergency department. However, instead of seeing the man, the staff clinicians assumed—because he was African-American and uninsured—that he was seeking drugs, and they discharged him without treatment.

The man suffered for several more days before finally seeking help at Mercy Primary Care Center, a Trinity Health-funded clinic operating in one of metropolitan Detroit's most impoverished areas. A clinic doctor diagnosed him as having a cyst on his spine. The cyst was drained, the man is now walking and working again—but the indignity of the emergency department experience remains. A simple procedure was denied him because of an assumption.

This form of discrimination is nothing new to the staff at Mercy Primary Care Center, who minister to a community that is 80 percent African-American and 37 percent uninsured. They see the ugly effects of health care disparities every day and work tirelessly to give their patients high-quality care delivered with respect.

Racial intolerance should never happen in any health care environment. Sadly, however, health care workers often see the ugly results of discrimination, including bad treatment outcomes due to cultural incompetence. I believe that my position as a health care executive and a leader of people—combined with my spiritual and religious beliefs—require me to try to do something about it.

The Moral and Cultural Imperative

People like us are in health care to make a difference, to save lives, to improve the health of all people. This passionate dedication is what differentiates our work from all others. Acceptance of anything less diminishes our noble profession. Thankfully, the vast majority of health care leaders are passionately committed to healing and improving the health of their communities.

And, indeed, there are countless stories showing how well we usually carry this commitment out. But are we committed to serve *everyone*? Clearly, we can do better.

An estimated 47 million Americans lack health insurance, and millions more do not have basic access to appropriate, equitable, and compassionate care. Minorities are much more likely to be uninsured than white people. About one-third of Hispanics and Native Americans are uninsured, compared with 13 percent of whites. The uninsured rates for African Americans—21 percent—and Asian Americans—19 percent—are also much higher than that of whites.[1] Gaps exist in the way people are treated, and these disparities parallel racial and ethnic backgrounds, regardless of income. In our communities, there are ethnic populations that perceive the U.S. health care system as serving some members of society well—and either neglecting others or serving them without full sensitivity to their pain and suffering.

With over 30 years of service behind me, I continue to believe that my mission, and that of my profession, is to care for all who are ill, especially those who are most vulnerable. This is especially true of Catholic health care providers.

The guiding principles of Trinity Health, Novi, MI, are shaped by Catholic social teachings that promote diversity and inclusion. Three foundational principles have a particularly direct correlation with the values of diversity and inclusion, both of which can and should apply to every organization, whatever its heritage. Those principles are:

- *Human dignity* Every person is sacred.
- *The common good* Society should support the health and welfare of all its members, so that all can flourish and contribute to the general good.
- *Participation* Health care organizations

should recognize the interconnected nature of human relationships and evaluate the impact of health care practices, policies, and actions on all segments of the organization and the community.

We must close the social distance between our organizations and our communities. In recent years, researchers have published startling statistics indicating differences between whites, on one hand, and minorities, on the other, in mortality and morbidity in every major category of health measurement, including infant mortality, heart disease, stroke, and lung disease.

The nation's population is becoming more diverse. In 1950, the Census Bureau reported that the United States had nine Caucasians for every person of color. In 1980, the ratio was 4 to 1. Today, the ratio is closer to 2 to 1.[2] Unfortunately, health care has not kept up with population shifts. Minorities are underrepresented in the physician workforce. According to the American Medical Association, the number of minority physicians remained static from 1999 to 2005, creating an even greater gap in representative care.[3] And the prognosis for the near term doesn't look much better. Too few minority health care professionals are coming out of the nation's nursing and medical schools.

Health care is a barometer of society. The lack of diversity in the ranks of caregivers is a fact that health care leaders rarely discuss. This is a mistake on their part because health care needs a culturally competent workforce to help eradicate disparities and inequities in care delivery and outcomes. If health care organizations are to adapt themselves to a changing environment, they must recognize the urgency of their situation and be proactive in their efforts.

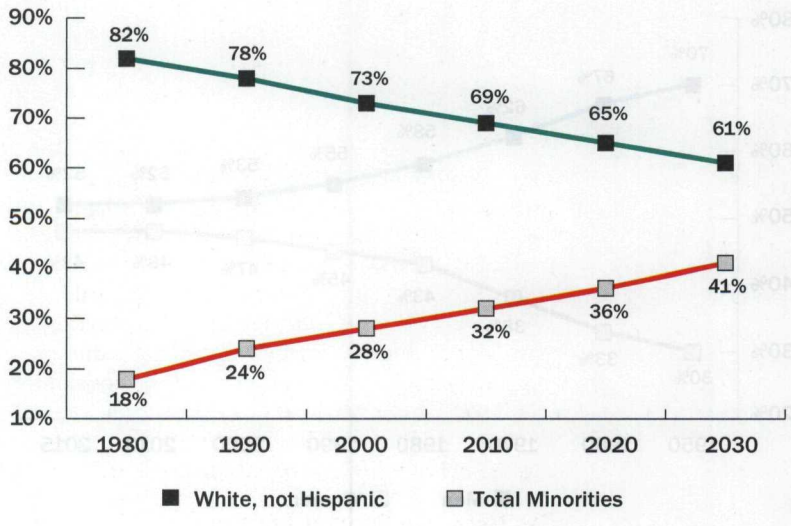
The need for action is reinforced by recent research, including a 2002 study from the Commonwealth Fund suggesting that when a physician and a patient share the same racial or ethnic background, patient satisfaction with the quality of care received tends to improve.[4] Another study, conducted by the Sophie Davis School of Biomedical Education among HIV/AIDS patients in New York City, found that racial concordance between patient and provider helps a patient to better understand and navigate the health care system.[5]

Other studies also show evidence of disparities and inequities. The *National Healthcare Disparities Report, 2005,* found that disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system.[6] In some areas, in fact, U.S. health care is actually getting *worse.* For example, the report found disparities between white and black patients in the hospital treatment of pneumonia.

The work before us will require an effort like the movement that arose in the 1970s to improve the quality, quantity, distribution, efficiency, and effectiveness of caregivers in the United States, especially in rural areas. In response to a 1970 Carnegie Commission report, the nation mobilized federal and state funding to transform higher education, including medical, nursing, and allied health education.[7] That commitment improved access to health care in many communities, especially rural locations distant from academic medical centers.

As our country becomes more ethnically and racially diverse, health care must respond to patients' cultural heritage, varied perspectives, values, beliefs, and behaviors concerning health and well-being. I believe that a strong and unified commitment from all sectors of health care—like the effort that expanded medical education in the 1970s—is essential to bring a cultural balance to

Race/Ethnicity Distribution in the U.S. Workforce from 1980 to 2030



Source: Toosi, Mitra: "Monthly Labor Review May 2002. A century of change: the U.S. labor force, 1950-2050" Totals may add up to more than 100 percent due to rounding.

the workforce and extend culturally competent care that improves patient safety and outcomes.

It Starts from the Top

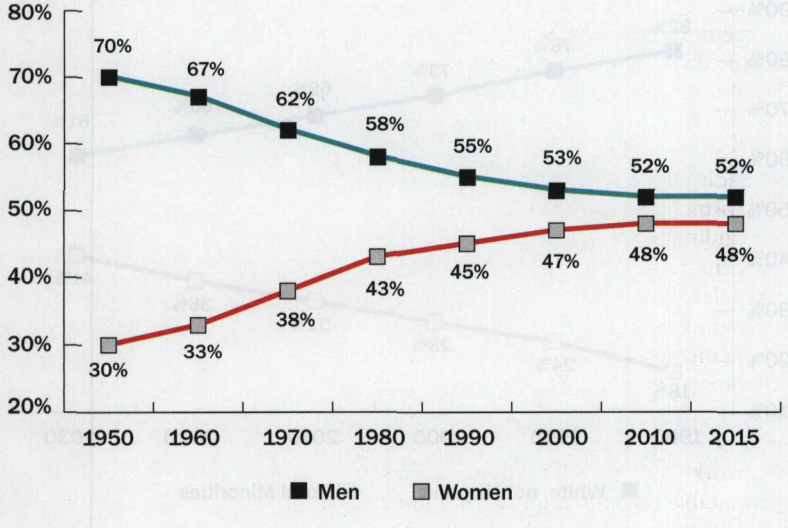
If this effort is to be successful, health care leadership must be the catalyst. A diversity imperative must come from the highest levels. Leadership's vision, moral and business commitment, and visible participation are more powerful than any written statement alone can be. It is especially vital that CEOs make a commitment that is authentic and permanent. Such a commitment is the first step toward the long-term success of diversity initiatives.

A culturally competent workforce is better able to effectively and respectfully serve a rich variety of cultures, ideas, experiences, and perspectives. Unfortunately, people of diverse backgrounds, the very people we are attempting to serve, sometimes feel alienated from health care because of certain acts—most of which are unintentional—by nonminority health care professionals. Consider, for example, five barriers that can lead to intolerance in the workplace:

- A lack of leadership commitment/engagement concerning cultural diversity
- A lack of understanding of diversity and/or marginalization of its importance
- An unsupportive organizational culture
- An unrealistic diversity strategy or one whose progress (or lack of it) is impossible to measure
- A failure to integrate diversity into the mainline business process, including customers and associates

All of these barriers can be overcome with committed leadership.

Gender Distribution in the U.S. Workforce from 1950 to 2015



Source: Toosi, Mitra: "Monthly Labor Review May 2002. A century of change: the U.S. labor force, 1950-2050" Totals may add up to more than 100 percent due to rounding.

Trinity Health's Strategy

Trinity Health is working to create a more diverse workforce and close the disparity gap. Our 19 regions, served by 46 acute care hospitals, have changed dramatically in just a few decades. Holy Cross Hospital in Silver Spring, MD, relies on 190 volunteer interpreters who together speak a combined total of 62 languages. In Fresno, CA, 36 percent of the population served by St. Agnes Medical Center is Hispanic. In Columbus, OH, Mount Carmel Health System serves a large Somali population, and in southeastern Michigan, St. Mary Mercy Hospital, Livonia, MI, is situated to serve the largest concentration of Iraqi-Americans in the nation.

In the midst of this cultural richness, Trinity Health strives to be the employer of choice in each of its communities. It is committed to the development of its human resources and to creating workplaces that nurture the human spirit and respect diversity. In all of our actions and decisions, we strive to recognize and respect the sacredness of life, the dignity of all persons, and the needs of the whole person—spirit, body, and mind. Our decision making is characterized by social analysis and discernment that reflect a commitment to meeting the needs of our communities and to promoting diversity.

Our system's "Statement of Mission and Core Values" recognizes the importance of diversity and inclusion in the way it emphatically states our commitment to *respect* and *social justice.* I encourage all health care leaders to closely examine their own organizations' statements of mission and core values in the light of possible cultural implications. Leaders should consider how such statements can advance the performance they expect as culturally competent organizations.

As is probably the case for most health care

organizations, Trinity Health's mission and values statement is the foundation for its expectations concerning performance and service. When I became CEO two years ago, I understood the need for the system to be a culturally competent organization as a response to the changing fabric of its communities. I sensed that Trinity Health's leaders already desired a diverse and inclusive culture. But that strong desire required a catalyst for transformation.

One of my first acts as CEO was to appoint myself the system's chief diversity officer. I did that to send a clear message to Trinity Health's 45,000 associates that diversity was going to be a top priority in my administration. Since then, I've hired a senior vice president of diversity and inclusion to help advance those values throughout the organization. Toward this end, a leadership team created a strategy and three-year work plan that was then sanctioned by the system's senior leaders and board of directors.

This strategy has seven parts:

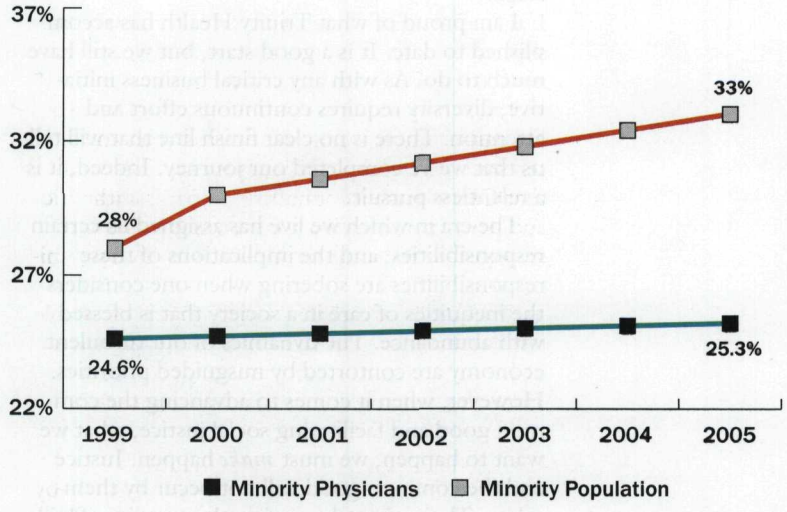
- *Commitment and Accountability* We hold leaders accountable for the creation, within their areas of responsibility, of an environment that supports diversity and inclusion. We have made this part of their annual evaluations.
- *Training and Education* We educate associates, physicians, and board members throughout the system on the "why, what, and how" of diversity and inclusion.
- *Recruitment* We have created recruitment strategies that support our ability to hire key talent throughout the organization. Accompanying these strategies are clear metrics that measure and track the success of our diversity efforts.
- *Communication* We have ensured that diversity and inclusion are incorporated into both internal and external communication materials.
- *Retention and Development* We have created development/career plans for top talent across the organization. With these plans, we identify leadership development opportunities through which associates can learn and grow.
- *Community Partners* In developing outreach and the delivery of culturally competent care, we consult with organizations representative of diverse groups in our communities.
- *Supplier Diversity* By working with diverse suppliers, including minority- and women-owned businesses, we both enhance economic development and further Trinity Health's community partner philosophy.

Leadership and accountability are integral elements of the plan's ability to achieve measurable results. In 2006, Trinity Health added a balanced scorecard standard that we call the "Circuit Breaker." Under the Circuit Breaker initiative, compensation depends on the achievement of specific diversity goals. At each of our sites, the CEO is required to create action plans to achieve specific diversity objectives over a period of two years. Sites are then evaluated according to a special audit template we've created. If *even one* of our hospitals fails to meet its diversity and inclusion audit requirement, we cut off the incentive compensation payments for all of our 200 participating leaders.

By implementing the Circuit Breaker, we sent a strong message that diversity and inclusion planning, management, and performance are indeed top priorities across our organization. "Benign neglect" is not accepted. Throughout our three-year work plan, we will hold our leadership accountable through regular communication, progress reports, and tying incentives to their performance.

We are already experiencing signs of dramatic cultural transformation. Our leaders are managing with renewed courage and compassion. Each

Minority Physicians in the Workforce vs. Minority Population from 1999 to 2005



Sources: American Medical Association. Federal and Nonfederal Physicians by Race/Ethnicity and Specialty, All physicians, December 31, 1996 and 1997; Total Physicians by Race/Ethnicity, 1998-2005; Resident Population Estimates of the United States by Sex, Race, and Hispanic Origin: April 1, 1990 to July 1, 1999; Annual Estimates of the Population by Age and Sex for the United States: April 1, 2000 to July 1, 2005.

of our organizations now has appointed a designated diversity leader. Through the example of these diversity leaders, we are sustaining an environment that inspires associates to experience a passionate dedication to their work, with a stronger sense of connectedness to those they serve.

I am proud of what Trinity Health has accomplished to date. It is a good start, but we still have much to do. As with any critical business initiative, diversity requires continuous effort and attention. There is no clear finish line that will tell us that we've completed our journey. Indeed, it is a relentless pursuit.

The era in which we live has assigned us certain responsibilities, and the implications of these responsibilities are sobering when one considers the inequities of care in a society that is blessed with abundance. The dynamics of our turbulent economy are contorted by misguided priorities. However, when it comes to advancing the common good and facilitating social justice, what we want to happen, we must *make* happen. Justice and the common good will not occur by themselves. Their triumph requires the exercise of will by leaders. Leaders' collaboration with others will provide guidance that either inspires change and progress or perpetuates discord.

Together, we health care leaders must and can make a difference. Our associates and our communities depend on us. Indeed, our very lives and well-being may depend on our leadership of a culturally competent system of care delivery. ■

NOTES

1. Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer: Key Facts about Americans without Health Insurance,* Washington, DC, October 2006.
2. U.S. Census Bureau, *Mapping Census 2000: The Geography of U.S. Diversity,* Washington, DC, 2000.
3. See American Medical Association, *Physician Characteristics and Distribution in the United States,* 2006.
4. K. S. Collins, et al., *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans,* Commonwealth Fund, New York City, March 2002 (www.kaisernet.org/health_cast/uploaded_files /collins_diversecommunities_523.pdf). See also P. Clark, "Prejudice and the Medical Profession," *Health Progress,* September-October 2003, pp. 12-23.
5. Sophie Davis Medical School, *Does Patient-Provider Racial-Ethnic Concordance Influence Ratings of Trust in People with HIV Infection?* City University of New York, New York City, March 2007.
6. Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2005,* Rockville, MD (www.ahrq.gov/qual/nhdr 05/nhdr05.htm).
7. Carnegie Commission on Higher Education, *Higher Education and the Nation's Health: Policies for Medical and Dental Education,* New York City, December 1970.

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