Diversity Is Inevitable, Disparities Are Not

By FRED HOBBY, MA, CDM

In 2015, how do we define diversity?

It encompasses every characteristic that makes one human being different from another. It includes marital status, height, weight, hair color, skin color, veteran status and the like — all of which can be benign or lead to stereotypical thinking.

Diversity also includes cultural differences such as preferred or primary languages, religious beliefs, grooming habits, grieving patterns, birthing practices and hygiene standards. Diversity includes differences in national origin, such as Irish, Italian, German, Polish, Korean, Vietnamese, Japanese, South American, Mexican, etc., along with the behaviors and values we have been taught by our parents, media and peers.

Then when we add such characteristics as gender, sexual orientation, race, ethnicity, age and socioeconomic background, it is no wonder that some try to avoid managing all these differences — or to pretend that they don't matter. This is a mistake. Diversity in America is inevitable, and its variables influence human behavior and the delivery of care.

As health care industry leaders, however, we have not learned how to manage diversity or to use it as a tool for developing equity in the workforce, much less in the delivery of care. As a result, diversity characteristics have evolved into barriers to teamwork, communication, efficiency and innovation.

I often cite the example of the young female Vietnamese patient whose mother brought her to the emergency room because of distressed breathing and respiratory problems. Upon physical examination of the girl, the ER nurse noticed abrasive scarring on her upper back and quickly notified Social Services, believing that the child may have been abused or beaten. The police got involved.

It turned out that the patient's grandmother had treated the girl with "coin rubbing" or "coining," a common Southeast Asian healing remedy rooted in Chinese medicine. The treatment, during which the skin, coated with massage oil, is stroked with the edge of a coin, raises red marks that fade after a few days.

Can you imagine the mother's surprise and embarrassment? If the ER staff had understood the family's cultural background and healing tradition, this unfortunate miscommunication could have been avoided.

I was involved in an incident involving an 86-year-old Muslim female patient who repeatedly tried to crawl out of bed in spite of a physician's order for "complete bed rest." The nurses got so frustrated, they threatened to use restraints.

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Nancy Stahl

I was called to the floor and brought with me an Arabic interpreter to translate as I explained to the patient that if she wanted to get well, she must remain in the bed. The patient informed me, via the interpreter, that if she was going to get well, she needed to get on her knees and "pray to her God ... five times a day." The interpreter then explained what the woman needed to do.

This may sound simple, but we turned the patient's bed to face the East — the direction of Islam's holiest site, toward which Muslims worship — and then she was fine with praying from bed. Without the Muslim interpreter's cultural understanding, we not only could have overlooked a simple solution, we might have compromised the patient's belief system, which certainly might have compromised her recovery and satisfaction.

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Stories such as these demonstrate what I mean when I say driving out variances in care that are based on race, gender, sexual orientation, language differences, culture, ethnicity and socioeconomic perceptions must become a national priority for the health care industry. Hospitals must become highly reliable organizations that achieve equity in all that we do.

WHERE TO BEGIN

What can we do as health care leaders? We must begin by examining our personal beliefs and cultural norms and realize they may not be the same for the people with whom we work. Nor may they be the same for those to whom we are entrusted with providing equitable and quality care.

We have to develop an inclusive culture that is not determined simply by numerical ethnic, racial and gender representation. An inclusive business culture is a belief system that encourages, solicits and values the diversity of thoughts, ideas and suggestions offered not only by the dominant group but also is inclusive of the diverse stakeholders, which include patients and employees in the organization's business culture. It is a mindset that values the different diversity characteristics identified above and seeks to embed the diverse elements at all levels of the organization.

THE ASSIMILATION TRAP

Assimilation to the dominant group's values, norms and behavior has been the standard for the past 100 years. This has been the path most chosen by immigrants entering the country from the 1930s until the 1960s. Along with requisite skills and education, assimilation has been the metric for recruitment, retention and promotion in most industries. It has excluded more talent than it has included.

Our management training programs don't focus on encouraging our workforce to become more innovative, or to think outside the traditional box. Historically we encouraged our up-and-comers to "think like me, talk like me, dress like me." Then we complain that we are not transforming our industry fast enough to meet the financial and quality goals of today or tomorrow. How can we expect better outcomes when we keep doing the same thing, over and over?

Managing diversity offers a different model and a different path to achieve the business, financial and strategic goals of the future. Hypothetically, even if an organization is completely composed of all white males (racial homogeneity), there still would be diversity characteristics such as religious differences, sexual orientation, generational differences and differences in socioeconomic backgrounds. The organization still would be required to manage its diversity if it hopes to achieve alignment among constituents and stakeholders in order to achieve the goals of the organization.

UNCONSCIOUS BIAS

Several years ago, I was invited by a nurse manager to attend a nursing unit staff meeting because the nurses were constantly squabbling with each other, not passing along vital patient information during shift change, and, in the manager's words, "just acting stupid." I anticipated I would find a typical rift between nursing aides, who would mostly be minorities, and registered nurses, mostly white, and I was prepared to discuss behaviors and perceptions.

When I arrived at the meeting, I was surprised to find approximately 16 people assembled, all of them registered nurses and all white. During the meeting, I spoke about teamwork and the common goal of providing our patients with a superior patient experience. During the meeting, everyone nodded his or her head in agreement with mostly everything I said. In short, I learned nothing about the cause of the squabbling.

I then decided to set up individual interviews to see if I could determine the root cause of the problem. Did I get an earful: The younger RNs complained about how slow the older RNs worked, meaning assignments frequently were not being completed by the end of the shift. They also referenced, among other things, the older RNs' condescending attitudes and how long it took the older RNs to enter information into the computer, also causing delays at shift change.

The senior RNs complained about the younger nurses' sense of entitlement, disrespectful behavior and unwillingness to occasionally stay overtime to ensure a smooth transition between shifts, especially on weekends. Both groups whispered complaints about a few "gay" nurses on the unit and their lack of focus when their friends from different units came to visit.

Based on those interviews, we put a training module in place on that unit to address unconscious bias. We paired the nurses with generational opposites and set incentive goals for each pair. Eventually the confusion and bias eased, then

BECOMING A CHANGE AGENT

Like many hospital executives, I stumbled into health care administration. After spending two years in the history department and two years in the sociology department at Washington University in St. Louis, where I was pursuing a PhD, I took my second real job as an instructor of black history and ethnic sociology courses at the University of Louisville.

I had a passion for improving race relations through my lectures, but teaching was not sufficient to quench my appetite for social change. So when a Louisville mayoral candidate offered me the opportunity to join his campaign staff and organize the black community to vote for him, I accepted. The candidate offered me $250 a month. When I told my mother I had accepted the job and resigned from the university, I thought she was going to kill me. Thank God he won... largely due to the black vote.

During those years in City Hall, I wrote the first municipal affirmative action plan in the country and served as Louisville's first director of the Affirmative Action Office. It was Marc Goldberg, the administrator of Louisville General Hospital, who approached me about race relations problems, labor relations challenges and Equal Employment Opportunity Commission complaints at Louisville General. He asked me if I thought I was up to the job of helping to resolve those problems. I accepted.

I was confident this position would finally allow me to pursue my passion. After countless discussions with rank-and-file employees, administrators and directors of local agencies, unions and ethnic organizations, we began to resolve the problems. These were true learning opportunities for me as I honed my skills as a change agent.

At this point, Humana, Inc., the nation's largest for-profit hospital company, acquired the formerly city-owned hospital from the University of Louisville, and the new CEO offered me an opportunity to join Humana, Inc.'s human resources department and continue to resolve the remaining issues inherited by the merger. I accepted.

After demonstrating some leadership potential, I was recommended for Humana's management training program. I accepted.

I spent the next 26 years as a hospital administrator, including serving several years as the CEO of Newport News General Hospital in Newport News, Virginia.

Throughout my career, I have encountered men and women, mostly white executives, who either provided opportunities for learning and advancement — and the chance to pursue my passion; or they offered barriers, insults and indignation. I offer this glimpse of my past not to brag, but so that readers understand that I became a professional in the race and ethnic relations arena through my life's experiences, my professional career and my formal academic training. I believe I am qualified to speak on the topic of race and ethnic relations as a historian, and to evaluate the progress of diversity in health care as a sociologist, and having been the first black hospital administrator at Bayside Hospital in Virginia Beach, Portsmouth (Va.) General Hospital, and the Greenville (S.C.) Hospital System. Ten years as president and CEO of the Institute for Diversity, or, as I like to describe it, the Chief Consulting Officer for thousands of American hospitals, has been the icing on the cake.

— Fred Hobby

was gone. By the way, two years later, that unit was recognized for achieving some of the highest patient satisfaction scores in the hospital.

The lesson: If anyone thinks diversity is just about race or ethnicity, they are light years behind in their thinking. So I offer the following suggestions:

- All leaders need to accept the fact that diversity, like change, is inevitable. The various minority patient populations have increased on average from 28 percent to 31 percent in the last three years, according to the Institute for Diversity's 2014 Benchmarking Survey of U.S. Hospitals (1,129 hospitals, or 19 percent of the field, participated). When you consider the comparatively poor health status of minority populations today compared to non-minority populations, and the disproportionate level of health disparities due to social and economic determinants, we can expect minority patient populations to continue to disproportionately increase as the general minority population continues to grow.
- The diversity of minority patient populations needs to be reflected on hospital boards and among the executive leaders in the C-suite. This goal is not purely about numerical representation. Rather, it is a strategic platform that ensures the presence of individuals that originate from and reflect the diversity of cultural beliefs, languages, social experiences, religious practices and values of the patients being served.

Obviously, executives and board members must bring the skills and business acumen necessary to contribute to the financial well-being of the organization. Additionally, minority board members and executives can serve as cultural brokers as well as advocates to ensure that the unique needs of the specific patient groups they represent are considered when the hospital is expanding or contracting services.

Forming employee resource groups can be helpful when considering revisions in visiting policies, security policies, dietary offerings and acknowledgement of religious holidays. These are just a few examples of the issues and topics where minority board members and executives can offer their expertise. We are entering an era in which patient satisfaction is becoming a factor in the reimbursement equation, and having leaders who are culturally competent because of their life experiences should be viewed as a strategic advantage rather than a threat to the status quo.

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PERSISTENT DISPARITIES

Hospital employees and health care workers in general are some of the most caring and compassionate people I have ever met. Bedside caregivers, clinicians, physicians, housekeepers and throughout the workforce of health care organizations, folks risk their personal health to serve others. They frequently sacrifice family time for patient time and continuously give of their skills and talent, and more than occasionally give their personal resources to improve or preserve the quality of life of others.

Nevertheless, health care workers are human beings. Health care workers, like all other workers in all other industries, bring their stereotypes (good and bad), their personal and religious values and their socioeconomic perspectives to work every day. Hospitals often are the largest employers in their communities, and they have one of the most educated workforces in the nation. Yet hospital leaders and their employees have not been able to stem the tide of health status disparities, and they are just beginning to reduce the disparities in the delivery of care.

As the American minority populations continue to edge toward majority status — projected to occur by 2050 or sooner, according to the U.S. Census Bureau — the persistence of disparities in care and medical outcomes will create financial threats for hospitals and serious challenges

for the nation's productivity. An unhealthy majority, led by an unconscious homogenous minority, is a recipe for disaster.

Managing the diversity of the workforce and the patient population gives forward-thinking hospitals an opportunity to create a competitive advantage in their respective marketplaces by reducing preventable errors, readmissions and miscommunications that result in longer lengths of stay, unnecessary tests and patient and provider dissatisfaction. Yet its adoption has been slow in some organizations and nonexistent in most. Hospital executives and board members need to ask themselves the following questions:

- Do our minority/diverse patients have a longer length of stay?
- Do our minority/diverse patients provide lower patient satisfaction scores?
- Do our minority/diverse patients have a greater percentage of readmissions?
- Do our patients with limited English proficiency experience more avoidable errors than the general patient population?
- Has the organization had more than three EEOC complaints this year?

Managing the diversity of the workforce and the patient population is a tremendous strategic tool for avoiding unnecessary costs associated with the questions above. If your answer is yes to three or more of the questions, chances are your bottom line is being compromised by practices that are avoidable and correctable.

The health care leaders of today need to develop a long game. There must be a sense of urgency about correcting imbalances and disparities. Having the courage to embrace the future includes the courage to embrace and manage diversity. Remember, diversity is not just about race.

FRED HOBBY recently retired from the Institute for Diversity in Health Management, Chicago, after 10 years as president and CEO.

A PRAYER FROM THE HEART

When a boy is born around
these parts
seems like everybody
and her mama holds they breath

feeling the heart beating the throat
closing shut
the eyes straining not
to see the future

hoping against the storm
we smooth the skin
making our fingers learn a memory for when

we are going to wish for skin to love
for eyes to blow the grit from
for

shoulders to clutch and caress
for dreams to feed our prayers into

the boy was running from something
and running to somewhere
that is all
we have ever known

my fingers would have caught him
if I could

now all we got is a story that
makes no sense
and fingers that hurt to hold

just one more time

— *Luke*

JOSEPH BROWN, SJ, who publishes his poetry under the name Luke, is a professor in the Africana Studies department at Southern Illinois University at Carbondale, Carbondale, Illinois. This poem appears in *The Sun Whispers, Wait: New and Collected Poems* (Makanda, Illinois: Brown Turtle Press, 2009).

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