

# Ending Disparities of Care Is a Matter of Social Justice

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By KEVIN LOFTON, MHA, FACHE

In many ways, the Catholic health care ministry in this country is at its zenith. Hundreds of high-tech hospitals deliver top-quality care to millions of patients, providing financial assistance to those in need and reaching out to their communities to help improve the health of entire groups and populations of patients.

Unfortunately, not every population or patient receives the same attention, treatment or outcomes.

To a disturbing degree, we continue to fail many of the very individuals who serve as the foundation of our ministry and our mission: America's underclass — ethnic and racial minorities, the poor, the aged and the vulnerable.

Despite progress in recent years, the health care industry in this country still too often unintentionally treats these individuals and communities as second-class citizens, perpetuating a systemic pattern of inequity and disparity of care among certain disadvantaged populations, particularly ethnic and racial minorities.

The principles of social justice call on us to aggressively and effectively address these disparities and to work together to create a system of

equal care for all those we serve — regardless of race, ethnicity, language or socioeconomic status. It's an issue that first found focus and widespread attention when the Institute of Medicine released a comprehensive report in 2002 titled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.

In April 2015, the Agency for Healthcare Research and Quality, a division of the U.S. Department of Health and Human Services, published the *2014 National Healthcare Quality and Disparities Report*, which assessed about 250 measures of quality and disparities over a wide spectrum of health care services and locations through 2012.

Among the findings: Disparities in quality and outcomes by income and race and ethnicity are large and persistent, and they did not improve substantially through 2012. People in poor households, the report added, "... experienced less access and poor quality," while blacks received worse care than whites in about one-third of all quality measures.

In other words, we're still struggling to properly address this issue some 13 years after the IOM highlighted the concerns in its groundbreaking study on racial and ethnic disparities in health care.

## PERSISTENT RECORD OF DISPARITIES

Racial and ethnic minorities in this country are re-

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ceiving lower-quality health services despite improvements in the overall health of the U.S. population. They experience higher rates of morbidity and mortality than non-minority populations, and they are less likely to receive the kinds of routine treatments and preventive care that are so vital to a healthy life.

The diabetes-related death rate among blacks in the U.S. is about 50 per 100,000 patients — nearly twice the ratio among whites.

Hispanics, meantime, are almost twice as likely as non-Hispanic whites of the same age to have diabetes. Some other illustrations of these disparities:

Black women have the highest death rates of all racial and ethnic groups and are 40 percent more likely to die of breast cancer than white women, the U.S. Centers for Disease Control and Prevention reports. (Nearly 1,800 fewer black women would die each year of breast cancer if death rates were the same as white women.)

Blacks are 70 percent more likely to have been diagnosed with diabetes compared to non-Hispanic whites, and about 2.2 times more likely than non-Hispanic whites to die from the disease.

Our ministry has made some headway in recent years in focusing improvement efforts on the “six aims” — the call by the IOM for health care to be safe, effective, patient-centered, timely, efficient and equitable. But I would suggest that we have not invested enough of our time and resources on that last aim — ensuring that race, ethnicity, gender and income do not prevent anyone from receiving top-quality care equal to that of any of our patients.

In mid-May, the first sentence of a front-page story in the Sunday edition of the *New York Times* read, “In virtually every field of medicine, black patients as a group fare the worst.” That introduction was written by Damon Tweedy, MD, a black psychiatrist at Duke University Medical Center, whose guest article in the newspaper’s “Sunday Review” section went on to add this important context to the statement: “This was one of my first and most painful lessons as a medical student nearly 20 years ago.”

“The statistics that made my stomach cramp back then,” Tweedy wrote, “are largely the same today: The infant mortality rate in the black population is twice that of whites. Black men are seven

times more likely than white men to receive a diagnosis of HIV, and more than twice as likely to die of prostate cancer.”

Tweedy’s impassioned and illuminating commentary focused on a single element of diversity: black physicians, who comprise just 5 percent of all practitioners in a nation where blacks represent about 13 percent of the population. Yet it served to further highlight how much work we

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have ahead of us if we are ever to create a truly diverse, equitable health care system that meets our mission and serves everyone in our society.

#### NATIONAL CALL TO ACTION

About five years ago, a group of national hospital groups — the Catholic Health Association, the American Hospital Association, the American College of Healthcare Executives, the Association of American Medical Colleges and America’s Essential Hospitals — joined in a “national call to action” to eliminate health care disparities and increase diversity in every aspect of the system.

The coalition identified three core areas and goals in its ongoing efforts: Expand the collection of data on race, ethnicity and language preference; increase cultural-competency training among clinicians and support staff; and boost diversity in management and governance.

As part of this coalition’s work, the Institute for Diversity in Health Management, an AHA affiliate, conducted a national survey to determine how — or if — hospitals were reducing disparities and increasing diversity. Some of the key findings indicate that we are making progress — slowly, incrementally, but surely.

Overall, the survey found, hospitals are actively collecting patient demographic data, including race (97 percent); ethnicity (94 percent); and primary language (95 percent). More than 86 percent of hospitals educate all clinical staff during orien-

tation, and approximately 65 percent of hospitals require employees to attend diversity training.

Like other health systems, CHI has significantly improved and expanded its collection of data on race and ethnicity. Data on race is collected in more than 95 percent of all admissions, up from about 70 percent four years ago. The figure for ethnicity is more than 85 percent, nearly double the number from four years ago. This essential demographic information allows CHI to report quality outcomes, uncover disparities and biases in care and develop care-delivery models around specific, disadvantaged populations.

Unfortunately, health care still has a long way to go in terms of diversity among management and governance. The AHA's 2013 survey on diversity and disparities determined that minorities comprised only about 14 percent of hospital board members, a percentage unchanged from two years earlier, and that minorities represented only about 12 percent of executive leadership positions, also unchanged from 2011. Only about 9 percent of all CEO positions are held by blacks.

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The single bright spot in the survey: The percentage of minorities in first- and mid-level management positions increased 15 percent between 2011 and 2013, rising to 17 percent. The AHA distributed a new survey in June 2015 to all hospital CEOs to help gauge progress since 2013.

At CHI, three of the 10 positions on the President's Council, the senior-most leadership committee, are held by blacks, and the organization is one of only two large national health systems in the country with blacks occupying both the CEO and COO positions. A key part of CHI's legacy is providing opportunities for everyone, and a job list for executives includes this guidance: "CHI is committed to having diverse leadership represented at every level of our organization. We call upon you as leaders to ensure that qualified,

diverse talent is brought forward into all final applicant pools."

The AHA and other national associations, including CHA, have been working collaboratively for many years to address issues of diversity and disparities in health care. In 2007, AHA created the Special Advisory Group on Improving Hospital Care for Minorities. I was proud to serve as the first chairman of that group, which later was renamed the Equity of Care Committee and continues its great work under the leadership of my friend and former colleague at CHI, Eugene Woods, president and chief operating officer of CHRISTUS Health. (See story on page 10.)

#### **TOOLKIT DEVELOPED**

In conjunction with AHA's diversity institute, the committee developed *Equity of Care: A Toolkit for Eliminating Health Care Disparities*, a free, 151-page resource guide that includes step-by-step instructions and key strategies on the three core areas of data-collection, cultural competency and leadership diversity. It is a document that we all can use as the foundation for improvement.

For its part, CHA has been actively spreading the word across the ministry about taking these important initiatives a step further through the creation of its Special Committee on Diversity and Health Disparities. The committee, led by Alex Valdez, vice president of international advocacy for CHRISTUS Health, advises the CHA board of trustees on issues around health disparities and leadership and workforce diversity.

The rapidly changing demographics in this country underscore the reality that reducing or eliminating disparities in health care is not only a moral obligation, but also a vital business imperative. The percentage of minorities in the U.S. population, now just over 37 percent, is expected to increase to about 57 percent by 2060, according to the U.S. Census Bureau. The total minority population, the bureau said, will double from about 116 million to more than 241 million. The black population will increase by about 50 percent to almost 62 million, a number that will represent approximately 15 percent of the total population by 2060.

If disparities are not eliminated, this rapid growth and demographic change will only exacerbate the impact on U.S. public health — especially



if the burgeoning minority population is not effectively integrated into the health care workforce of the future.

As an industry and as a nation, we must look at the issues around disparities and equity of care from a broader context than in the past — especially as we move to a value-based payment and delivery model that emphasizes care not only for individuals, but also for certain defined populations or designated groups.

Those populations and groups — some with disproportionately large percentages of ethnic or racial minorities — can range from chronic users of emergency department services to diabetes patients to individuals suffering from chronic obstructive pulmonary disease.

Of course, the task of creating and sustaining healthier communities is nothing new to the Catholic health care ministry or to CHI. It has been CHI's mission since its creation more than 19 years ago.

But as we continue to reach out to our communities, expanding outpatient services and focusing on an array of social determinants of health as we accentuate “well care” rather than “sick care,” we must strive to reflect the people and the populations we are serving. It's the first big step toward providing effective, culturally competent care in a new environment fostered by the Affordable Care Act.

As we make this transition and adapt to these changes, we are learning to provide care in a different way as issues such as equity, diversity and disparity provide an even more urgent impetus for change.

Traditional medical care accounts for only a relatively small portion of “healthy living” — about 20 percent or so. Most of our total well-being depends on behavioral, environmental and socioeconomic issues like income, social status and education. Higher incomes translate to better health and access to medical care. Education levels, physical environments and the availability of social-support services also have a direct impact on health status.

We need to be mindful of that and open to restructuring or re-assessing services to address these needs outside the walls of our hospitals.

In fact, CHI has its own Equity of Care Committee, formed about four years ago and composed of

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top leaders in both operations and mission. The goal is to go “upstream,” that is, work to effectively address social determinants of health and establish how they impact patients before they contract chronic conditions or become more vulnerable to other societal forces.

In Louisville, Kentucky, for instance, an innovative care-management program called the Health Connections Initiative identifies patients in low-income neighborhoods who are frequent users of hospital services and emergency departments. The program, funded through a CHI Mission and Ministry Fund grant and managed by CHI affiliate KentuckyOne Health, provides home visits, a wide array of social services and support from a network of providers, including a primary care physician.

The goal is to help manage the medical conditions by dealing with closely associated determinants of health that influence our overall well-being. That includes housing conditions, low literacy, availability of transportation and difficulty in obtaining nutritious foods in impoverished neighborhoods.

Only with such a comprehensive approach can we care for our patients in mind, body and spirit. Equitable, person-centered care is integral to our mission, to social justice and to our faith tradition. We cannot achieve our goals as a health ministry with a continuation of these wide variations in care and quality. And we cannot eliminate disparities in health care unless we have diverse leaders who bring cultural perspective and personal connections to their roles and responsibilities.

It's a simple equation for our Catholic health care ministries: We must work together to create a more diverse, inclusive health system that helps to reduce or eliminate disparities — and ensures that everyone we touch is treated with dignity and respect.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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Reprinted from *Health Progress*, July-August 2015

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