HEALTH CARE'S CALL TO ACTION

The Good Samaritan, Inclusion and Diversity

By EUGENE WOODS, MBA, MHA, FACHE

What does it mean to "Love your neighbor as yourself?"

Jesus provides us with an answer in the parable of the Good Samaritan — it means stopping to help when no one else will. It means offering hope and healing to those who need it most. In short, it is our raison d'être as Catholic health care providers — it is the reason we were founded and core to who we are.

But as in all parables, there are other profound lessons to be learned beyond the immediately obvious. The Samaritan, who stopped to help an injured man when a fellow Jew and holy man would not, teaches us a deeper lesson about helping those who are different from us.

As we know, in Jesus' day there was a seething hostility between Jews and Samaritans. So when the Samaritan stopped to help a Jew who had been stripped of his clothing, beaten and left for dead, he was setting aside deep bitterness and cultural conditioning in order to care for someone with very different values, customs and rituals.

Herein lies the more profound teaching of the parable, and it forms the foundation for our calling as Catholic health care providers to eliminate disparities and achieve equity of care for all who have entrusted their lives to us — to care for all members of God's creation.

Unfortunately, however, not all of us are stopping to help our fellow neighbor. To cite a few statistics, according to the Agency for Healthcare Research and Quality's (AHRQ) annual quality and disparities report,[1] Hispanics have worse access to care than non-Hispanic whites for about 65 percent of core measures. Furthermore, according to a recent report from the Dartmouth Atlas Project, African-Americans are less likely to get routine preventative care than other patients and three times more likely to lose a leg to amputation, a devastating complication of diabetes and circulatory problems, and a treatment of last resort.[2] Significant disparities also exist relative to inpatient care for minorities with heart failure, for instance. Among Medicare enrollees, congestive heart failure hospitalization was higher in blacks, Hispanics and American Indians/Alaska Natives than among whites, and stroke hospitalization was highest in blacks.[3]

Not only is the existence of these disparities inconsistent with the call that emanates from stories like that of the Good Samaritan, it is incumbent on us in Catholic health care to do better and to lead the way.

At CHRISTUS Health, enhancing diversity and equity of care has been part of our ministry starting in the 1860s when the founding sisters traveled from France to treat the sick and infirm in the new land of Texas. In 1869, the sisters in San Antonio wrote to the newspaper about a hospital they were establishing, stating that "the hospital will be open to all persons without distinction of nationality or creed."[4]

The sisters in Houston expressed the same commitment to equity of care.

DIVERSITY AS STRATEGY

In 2011, CHRISTUS Health developed a new strategic plan that included a recommitment to the values of our founding congregations: to respect in

both words and deeds the dignity and worth of each and every human being, regardless of color or creed. This reaffirmation led us to establish a culture of diversity and inclusion as one of our ministry's core strategic objectives; more specifically, it included a commitment to diversity in leadership and equity in care. This was then baked into our metrics throughout CHRISTUS, and the executive leadership began reporting monthly on progress towards our diversity and inclusion (D&I) strategic goals, using a system-wide scorecard to assess the performance of our top 200 senior leaders.

Our strategic reconnection to heritage was key in deepening our associates' understanding that creating an inclusive environment is not only part of our ministry's DNA, but directly linked to our future success, especially given that the United States is becoming significantly more diverse demographically — and certainly in the communities we serve in Texas, Louisiana and New Mexico. Specifically, the U.S. Census Bureau has projected that racial and ethnic minorities will outnumber the white population by 2042. In fact, nearly 60 million people —19 percent of the U.S. population — already speak a language other than English at home.[5] Additionally, minority communities are growing in economic power. In fact, according to the University of Georgia's Terry College of Business, minority buying power already exceeds $2 trillion.[6]

Training in cultural competency will increase clinician and staff awareness and help hospitals and systems ensure that patients receive high quality, patient-centric care.

So not only is advancing a culture of diversity and inclusion the right thing to do from a social justice perspective, but any organization that ignores the implications of these seismic demographic shifts does so at its own economic peril.

EQUITY IN ACTION

Recognizing these trends, CHRISTUS proactively began to diversify leadership and focus on minority populations to ensure that no disparities exist in managing care. We also began forming and engaging leaders and the workforce by providing cultural competency training, and cascaded these expectations from our senior leadership teams to all managers, including nurse managers.

We also trained our front-line associates to accurately collect each patient's race and ethnicity data, which was then used to track and analyze specific quality outcomes. Thus far, we have not found disparities in care for a select number of quality indicators, but our analysis continues. In fact, we are installing new technology to help analyze this data concurrently throughout the organization so we can implement more real time remedies as needed. This implementation will further advance our efforts to collect accurate race, ethnicity and language (REAL) data in order to better understand the needs and outcomes of the populations we serve.

As for our results, over the last three years, the ethnic and racial diversity of the top 200 leaders in the organization has increased from 13 percent to 23 percent. And the average minority representation on our boards is now 30 percent — which is twice as high as revealed in the most recent Institute for Diversity in Health Management survey of the field.

Also, to ensure the continued focus on our diversity and inclusion initiatives, we tied the pay-at-risk incentives of leaders to the achievement of our diversity and inclusion goals, including cultural competency training — which 99 percent of all senior leaders have now participated in since our strategy was put into place. In addition, we launched an Executive and Administrative Fellowship program, which creates opportunities for CHRISTUS executives to identify and develop a new generation of diverse leaders who demonstrate high potential. Since the start of the program, three fellows mentored by CHRISTUS leaders have joined the ranks of our hospital executives.

Sadly despite these efforts, and those of other organizations, as a field we have not performed so well as measured by the significant disparities that remain today. To be sure, some progress has been made, but enormous gaps remain. And

in addition to the toll in human suffering, these disparities have resulted in enormous costs due to medical errors, increased length of stay and avoidable readmissions. In fact, a Johns Hopkins study demonstrated that eliminating care disparities would reduce direct medical expenditures by over $450 billion for black and Hispanic men alone.[7]

Additionally, a survey by the Institute for Diversity in Health Management, an affiliate of the American Hospital Association, found that while more than 90 percent of hospitals are tracking racial data and measuring patients' primary languages, only 22 percent of hospitals are using this data to assess and identify potential gaps in care, whether in clinical quality indicators, readmissions or core measures from the Centers for Medicare and Medicaid Services.[8]

CALL TO ACTION

As a member of the AHA board and chair of AHA's equity of care committee, I, along with my colleagues, have established a pathway to close the gap through the National Call to Action to Eliminate Health Care Disparities. The genesis of this initiative was a group formed in 2011 by the AHA in partnership with the Catholic Health Association, American College of Healthcare Executives, Association of American Medical Colleges, and America's Essential Hospitals. We felt that for too long the issue of equitable care had been relegated too low in the priority list for our nation's hospitals, and that it was time to make it a top priority. Not only that, but we knew you simply can't solve for population health issues without solving for disparities.

Therefore, we stood together in this call to action and publicly announced our intention to meet key improvement goals toward equality in care, with specific timelines and milestones. We deeply believed then, and still do, that health care leaders possess a tremendous opportunity to make a difference in the lives of so many by decreasing disparities through three key initiatives, including:

- Increasing the collection and use of race, ethnicity and language preference data
- Increasing cultural competency training
- Increasing diversity in governance and leadership

These three elements represent a pragmatic and evidenced-based approach to eliminating disparities in care. Through consistent and reliable data collection, hospitals and systems can better understand the characteristics and needs of the communities they serve, identify differences in care, target quality improvement activities and track progress. Training in cultural competency will increase clinician and staff awareness and help hospitals and systems ensure that patients receive high quality, patient-centric care. Greater diversity in board and leadership positions will ensure that hospitals and health systems reflect and have greater insights into the communities they serve.

So to gauge our progress as a field, the Institute for Diversity in Health Management and Health Research & Educational Trust has conducted a biennial survey of hospitals on the National Call to Action goals.

Unfortunately the survey findings since the baseline from 2011 reflect a slow progress. The above chart highlights where we are and where we, as the Call to Action effort, need to be:

Milestones by year	Collection and use of race, ethnicity & language data	Cultural competency training	Increasing diversity
2011	18%	81%	Governance, 14% Leadership, 11%
2013 (Progress data)	19.4%	86.4%	Governance, 14% Leadership, 12%
2015	25%	90%	Governance, 16% Leadership 13%
2017	50%	95%	Governance, 18% Leadership, 15%
2020	75%	100%	Governance, 20% Leadership, 17%

Some key gaps are noted in the chart. For example, the patient population represented by minorities was 31 percent in 2013, while minority representation in hospital leadership and governance lagged, with only 14 percent of hospital board members and an average of 12 percent of executive leadership positions held by minorities.

WHAT YOU CAN DO NOW

In sharing these results with colleagues, we have received great feedback. Though the responses have run the gamut, the most common refrain

seems to be, "I really do feel strongly that something needs to be done, but where do I begin?"

So here are actions you can take before the end of this year, when the next survey will occur:

- Choose a quality data measure to stratify by race, ethnicity and language preference. (CMS core measures are a great starting point, as are readmission rates or HCAHPS questions.) Then, determine if a health care disparity exists and, if so, implement a plan to address this gap.
- Finalize a plan to ensure your staff receives cultural competency training.
- Concurrently, have a dialogue with your board and leadership team about how you reflect the community you serve and what actions can be taken to address any areas of concern.
- Call five additional colleagues in the field to share your journey and enroll them in this effort. This may be the most important step, in terms of keeping up momentum.

And, you don't have to reinvent the proverbial wheel. There are great resources to help you at www.hpoe.org/resources and www.equityofcare.org, which includes a compendium of best practices that will guide you through each step highlighted above.

As Martin Luther King once said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." We as Catholic health care providers must continue to lead the charge in eliminating disparities and increasing diversity because it is the bedrock of our founding principles: to care for all, regardless of how different they are from us; to eliminate injustice when and wherever found; and to recognize the dignity of every person because we are all created in God's image and likeness.

The bottom line is that there are more than 7 million people of different ethnicity, race and language preferences who will be cared for in U.S. hospitals this year, not to mention the millions that we will treat outside of our traditional hospital walls. That provides us with more than 7 million opportunities to be a Good Samaritan — to love our neighbors as ourselves.

The time is now to stop, on our own journey from Jerusalem to Jericho, and help our brothers and sisters, no matter what they look like, no matter where they are from. My faith that we will do so remains strong.

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NOTES

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