BIAS, DISPARITIES AND MISSION INTEGRATION

I have lived in St. Louis most of my life. The CHA office where I work is just a few miles away from Ferguson, Missouri, where in August 2014, a white police officer shot and killed an unarmed 18-year-old African-American man, Michael Brown, sparking protests, street violence, demonstrations around the country and worldwide media attention.

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Friends and colleagues who live in other parts of the country have asked me many questions about what happened in Ferguson, why it happened and how the community is trying to heal and move forward.

I usually tell people that racial tension has existed in the St. Louis area for a long time. The region's neighborhoods, for the most part, still are racially segregated. There has been distrust for decades between the African-American community and the police departments that serve municipalities in the St. Louis area, where positions of authority — including the police — do not reflect the local racial and ethnic composition.

Most St. Louisans were not surprised by the civil and criminal unrest that erupted after Michael Brown's death and again three months later, when the St. Louis County grand jury did not find cause to indict the officer. Over the months, deaths of unarmed black males at the hands of police elsewhere in the United States made it clear the situation is not unique to Ferguson, and the discourse reached a national level in confronting the fact that skin color, ethnic and cultural background still can govern the way people in the United States are treated.

This edition of *Health Progress* is focused on disparity and diversity and will be published as we approach the 1-year anniversary of Michael Brown's death and the Ferguson riots. Cities across the United States have been looking at the diversity training programs offered in their police departments, data that seeks to discover whether racial profiling is occurring and how to involve communities in partnerships that build trust between citizens and law enforcement personnel.

In Catholic health care, should we not be doing the same regarding diversity and health care disparity?

For well over a decade, health care institution and provider quality data has been analyzed for differences by race and ethnicity in care and quality outcomes. The research has shown disparities between white and minority patients. When researchers look at the reasons for these health care disparities, we find some of the same core issues as in racial profiling: Discrimination is often the result of organizational practices that have unintentional racial effects and are based on cognitive biases linked to social stereotypes.

And that is a mission integration issue.

The theological and moral issues involved were outlined in a 2012 CHA resource, *Righting Health Care Disparities: The Theological and Moral Imperative*, developed by Ron Hamel, PhD, then senior ethicist for CHA. In that presentation, Hamel shows how the principles of Catholic social teaching — including the inherent dignity of each person, the common good, and concern for poor and vulnerable persons — provide a moral and ethical basis for the Catholic health care ministry. He reminds us that these values call us to refuse to accept the existence of racial and ethnic disparities in health outcomes, access to care and receipt of quality health care. Disparities in health care are in direct opposition to the mission of Catholic health care and the Catholic social tradition.[1]

But it is not enough for mission leaders to know the theological and ethical imperatives for righting this injustice. We also need to be familiar with the research in this field and how to collaborate in the quality initiatives of our health systems.

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When I mentioned to a CEO that righting health care disparity in our system was a mission issue, she agreed — and made me co-chair of the Health Care Disparity Committee. Because of that appointment, I had to become familiar with the literature so that I knew not only the theological, but also the clinical and quality aspects of the conversation, as well.

One of the most valuable resources I discovered was the August 2012 Robert Wood Johnson Foundation special symposium, "Interventions to Reduce Racial and Ethnic Disparities in Health Care." One keynote presentation, entitled "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care," showed how to move from merely documenting health care disparities to identifying solutions to close the gap in care.[2] In this watershed research, the authors synthesize themes from 12 systematic reviews of the literature showing promising interventions that are improving the health care process and improving health care outcomes for minority patients. If you have not read this article, I highly encourage you to do so.

The authors of this work outline six steps that health care organizations, policymakers and researchers can use:

1 **Recognize disparities and commit to reducing them** — This involves stratifying performance data by race, ethnicity, language, payer source, etc. The process for collecting demographic data in an organization may need to be adjusted to ensure data is accurately and consistently collected at all the possible points of patient entry. Included within this step is the commitment to provide disparities and cultural diversity training to providers and staff. As in other types of education and formation, if we want to change behavior, training must be ongoing and not just a one-time, check-the-box approach.

2 **Implement a basic quality improvement structure and process** — Most health systems have these quality improvement structures in place, but in order for the initiatives to be successful, the authors highlight the need for a local champion and for leadership support. The local facility needs to own its problem with health care disparities so that staff will not perceive this as yet another system initiative being pushed down from on high.

3 **Make equity an integral component of quality improvement efforts** — Efforts to address disparity should not be marginalized or "silo-ed." They need to cut across all quality initiatives.

4 **Design the interventions** — This step includes discovering the root causes of disparities in the specific context of a facility and considering six possible levels of influence that may contribute to the intervention in a positive way: patient, provider, microsystem (that is, care team), organization, community and policy. In addition, the authors encourage literature review and evidence-based strategies while at the same time recognizing some interventions may have to be adapted, depending on geographic and ethnic and cultural factors.

5 **Implement, evaluate and adjust the intervention** — Organizations are not likely to find the perfect solution with one intervention. Health disparities are a complex issue, and ongoing evaluation and redesign are part of any committed quality improvement initiative.

6 **Sustain the intervention** — This requires emotional and financial commitment to righting an injustice. The ethical and moral imperative underpins ongoing commitment in Catholic health care, but so does the Affordable Care Act, which has built financial incentives (or more accurately, penalties) into its implementation plan to encourage systems to stay committed to reducing health care disparities.

In addition to the important steps outlined by this research, there are some other practical approaches that are making a positive difference in health disparities metrics.

First, it is important to connect the issue of

health disparities to other initiatives centered on diversity, inclusion and patient-centered care. At its best, patient-centered care takes into account the patients' language, cultural, religious and ethnic preferences and how their race and culture affects what they hear and how they relate to medical professionals when confronted with diagnoses and treatment decisions.

Although we have mentioned the importance of training in diversity and cultural competency for providers and staff, it is important that these initiatives be linked to mission for the theological and ethical rationale, as well as to the quality department so the impact of training can be measured as it relates to improvement in health disparities.

Second, just as police departments and cities across the country are involving community leaders to help them learn how to rebuild trust, so we in Catholic health care need to involve the community in our diversity and health disparities initiatives. The value of focus groups and task forces that include community members not only shows we need external input, they open the door to transparency and accountability. If we ask for the input and ideas of the community to solve this injustice, we must be willing to publicly report our metrics and show if we are making progress. Transparency and accountability are important elements in how police departments and health care organizations will build trust with minority populations.

Finally, we have heard over and over this past year that police departments in our country do not mirror the communities they serve. The need for hiring more minorities to serve in law enforcement is one of the first steps in showing commitment to a diverse workforce with a variety of perspectives and ideas that reflects the values and feelings of a diverse population.

The same is true in health care.

Do our health care facilities reflect the racial and ethnic composition of the communities we serve? This means the racial and ethnic demographics of our community are mirrored not only in the front-line staff who care directly for patients and residents, but also in the senior leaders, board members and sponsors. Rarely does a patient see them, but they are the ones ultimately responsible for ensuring all members of the community are served with respect and equity.

Recently, I returned from the annual CHA Ecclesiology and Spiritual Renewal Program for Health Care Leaders held in Rome. One participant was Regina Benjamin, MD, former Surgeon General of the United States and currently a board member of Ascension. During a reflection, Benjamin reminded us equity is not the same as equality.

She illustrated her point with a graphic. It shows three children standing on boxes to peek over the fence at a baseball game. Equality is sameness, so every child stands on the same kind of box — but the short kid can't see over the fence at all. Equity is fairness, rearranging the three boxes so that everyone gets the same view. The tall kid doesn't need a box in order to see over the fence, the middle-sized kid needs to stand on one box and the short kid needs to stand on two boxes.

As a nation, we continue to pray, discern and search for solutions that will help us become a more just and equitable society. We in Catholic health care can lead the way to address the injustice of health care disparities. We have a theological and ethical foundation to guide us. We have a commitment to quality and excellence, especially in serving the poor and underserved.

But are we humble enough to confront organizational biases that have contributed to the injustice of health care disparity? Are we committed enough to dedicate resources to hiring a diverse workforce and giving diversity and disparity training to all staff? Will we collaborate with community leaders in building trust through transparency and accountability?

If the answers are yes, then our health systems will demonstrate even greater respect, compassion and justice for those we serve.

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NOTES

1. Catholic Health Association, *Righting Health Care Disparities: The Theological and Moral Imperative*, January 2012, is available in the CHA Store on the CHA website: www.chausa.org.
2. Marshall H. Chin et al, "A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities in Health Care," *Journal of General Internal Medicine*, 27, no. 8 (August 2012): 992-1000.

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