

# When Healthcare Organizations Cultivate Diversity, Outcomes Improve

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Diversity in healthcare leadership is no longer a choice – it’s a business requisite that delivers a decisive competitive advantage. How can healthcare organizations build a diverse leadership team that drives organizational success and cultural competence? What are the benefits for patients, physicians and the broader workforce, and the impact on governance, quality of care and operational and financial goals?

At the ASHHRA Annual Conference, Witt/Kieffer CEO Jim Gauss explored the business case for diversity with panelists Sonja Boone, M.D., Director of Diversity at Northwestern Memorial Hospital, Chicago, and Juana Slade, Director of Diversity and Language Services, AnMed Health, Anderson, SC. During their discussion, they examined key issues involved in developing a healthcare culture that embraces diversity.

**Q. (Jim Gauss):**

First of all, how do you define diversity in a healthcare organization?

**A. (Sonja Boone):**

In our organization, we think about diversity in terms of three elements: representation, inclusiveness and cultural competency. Representation refers to how we reflect the communities we serve at every level of culture, background, religion, race and ethnicity – both in our general workforce and our management team. We also look at minority representation in our vendor pool.

Inclusiveness focuses on how we create a welcoming environment for all our staff and patients including mentoring programs, diversity training, management training and benefits. Cultural

competency defines how we deliver care in a way that is sensitive to and respectful of the cultural background of our patients and workforce. For example, do we have measures in place, and literally space for our Muslim employees to pray? How can we improve our language interpreting services? How can we reach out into the community and create solutions to eliminate healthcare disparity?

**A. (Juana Slade):**

Diversity is used in so many different industries and has come to mean so many different things across the country. Our organization wanted to adopt a definition that would be inclusive not only of the stereotypical dimensions of difference, but also differences in thought, socioeconomic background, education and so on. As a result, we

adopted the definition set forth by Dr. R. Roosevelt Thomas, Jr. of the American Institute for Managing Diversity: “Diversity is any collective mixture characterized by similarities and differences.” This broad definition allowed us to engage our entire organization in the diversity conversation. Our CEO, John Miller, who is also our organization’s leading diversity champion, has been one of our facilitators of diversity training and education. He has developed his own philosophies around diversity including his own term – “differentiology” – which simply means the science of “differentness.”

**Q. (Jim):**

How do you ensure that your workforce truly understands the meaning of diversity and your goals regarding diversity?

### **A. (Juana):**

We want to make sure that at a very basic level everyone in our organization understands what diversity means, so we have included a diversity module as part of our annual computer-based training requirements. As you move up in the organization, we offer approximately 15 to 20 courses through our internal AnMed Health University System so our employees – our managers and supervisors in particular – can create diversity learning opportunities for their staff.

“In our organization, we think about diversity in terms of three elements: representation, inclusiveness and cultural competency.” — Sonja Boone

One of our most recent accomplishments was to launch our own internal diversity leadership academy. This internal academy has allowed us to bring together a multidisciplinary team of individuals from across the organization. The team takes a look at some of the strategies we have put in place to deliver on language access, so we understand how those same strategies can apply to other areas in other functions across the organization. And finally, our executive team participates in a community-wide diversity academy that is hosted by one of the local universities.

### **Q. (Jim):**

How are diversity and quality of care linked? How can this connection be measured?

### **A. (Sonja):**

One of the ways to do that is to clearly identify metrics that will be tracked, followed, measured and monitored over time. In our organization, we decided to follow employee engagement as a measure of inclusiveness. For cultural competency, the final distilling down to

the metric of patient satisfaction is on our Press Ganey survey. We have a question that asks, “Were your cultural and spiritual needs met in the hospital?” We can benchmark that answer to 65 other hospitals that use Press Ganey. We also conduct a real-time patient satisfaction survey where we ask, “Are your cultural needs being met?” We are in the process now of refining that question to help our

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patients understand it better, because that gives us an opportunity to actually fix the issue while the patient is still here.

### **A. (Juana):**

We decided that if we could benchmark AnMed Health and establish some strategies and deliverables, we would be culturally and linguistically competent in the way that the care was provided. We began by attempting to benchmark ourselves against the recommendations of the 14 class standards as issued in 2001 by the Department of Health & Human Services Office of Minority Health. Over the past six years we have developed what we call our Language Services Program. I think it’s very important that we have individuals who have a clinical background involved in the validation of any diversity matrix and it’s important there is that connection to quality. As a result, we have established a partnership with the Medical Resource Management Department that has brought validity and credibility to our strategies.

To promote cultural competency, we created a data management system that

allows us to track our interface with the various populations that we serve, particularly those individuals who require language assistance. We've made sure that cultural competence is a part of our Gallup survey to our English-speaking patients and have gone a step further to create a survey for our Spanish-speaking patients. We are now able to compare the outcomes and performance of our Spanish-speaking patients against the performance of our English-speaking patients to look for opportunities for improvement.

**A. (Sonja):**

Cultural competency leads to better quality of care and a reduction in errors. I always refer to Juana's example of when AnMed began using an interpreter for every discharge of a patient who had limited English proficiency. When they looked at the data, those patients had less recidivism and better outcomes. That says that finding processes that work actually improves quality of care for everyone. When we started collecting information here on race, ethnicity and primary language, and then looked for disparities, we found glitches in the process that once corrected, improved quality of care for all patients. We're going to see that as we look at the process more closely, everyone will benefit.

"I believe a final frontier still remains with the executive suite and with our ability to create environments that will support successful candidates transitioning into successful employees." — Juana Slade

**Q. (Jim):**

How common is it for healthcare organizations to utilize these types of metrics?

**A. (Sonja):**

As we really drill into metrics, we're better able to get the buy-in of the senior management team and directors of the organization. But if I had to guess, I would say that less than five percent of the hospitals and medical centers are tying diversity and inclusiveness to quality from a metrics standpoint.

**A. (Juana):**

I would agree. However, I have been asked twice to present to our Board's Quality Coordinating Committee, evidence that the nation is beginning to look for the benefit and see the importance of this issue. I think it's important that we continue to make the connection between diversity and quality, look for opportunities to improve the quality of care and be able to document it.

**Q. (Jim):**

What is the impact of diversity on an organization's financial health?

**A. (Juana):**

As Sonja mentioned earlier, a couple of years ago, we embarked on a study that we thought was going to validate the belief that individuals who are limited English proficient and were admitted to the hospital system would probably have a longer length of stay and a higher readmission rate compared to our benchmarks. We certainly expected the disparity to be in favor of our English-speaking patients. Anecdotally, we found that the readmission rate and length of stay were slightly less for our limited English proficient patients who had received on-site language assistance. The reason that this mattered to our finance folks was obvious. It also caught the attention of the individuals in quality because they wanted to find out what exactly we were doing with this particular patient population.

The difference in those encounters, compared to the English-speaking encounters, was there was an interpreter. This speaks not only to linguistic competence but also our ability as a provider to understand and be sure that our patients have the information they need and their questions are answered –

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all in a timely manner. That saves money, I don't care who the patient is. So that says if we can spend the same time clarifying for our English speaking patients as we do clarifying for those individuals who don't speak English, we may be able to reduce length of stay and reduce readmission rates for all patients, irrespective of their language needs.

**Q. (Jim):**

Are healthcare organizations ready for diversity?

**A. (Juana):**

Our country is different than it was 10 or 15 years ago, so the way we recruit, the way we retain, the way we promote has to be different in our organizations. But it doesn't make sense to go out and recruit a diverse slate of candidates if an

still remains with the executive suite and with our ability to create environments that will support successful candidates transitioning into successful employees.

**Q. (Jim):**

What is the role of the board of trustees and senior management in promoting diversity?

**A. (Sonja):**

Really, really critical. If you have the buy-in and support from the level of the board, that will definitely be transmitted down in terms of accountability to the CEO and therefore to the senior management team, and you can affect change. There are times when the CEO can be in a very strategic position of taking action and then that trickles down into the organization. If he/she sets a tone of

“When you start ‘operationalizing diversity’ and place it into the priorities of the organization, you start to see results.”

— Sonja Boone

organization does not have a culture that says, “We’re going to create an environment across the entire organization that will allow this individual to be successful.” I’m convinced that providing care that is culturally and linguistically competent should come as a result of our concern for the delivery of patient care. But I believe a final frontier

diversity in the organization, that can also be communicated up to the board. When there is no traction at the level of the board or the CEO, then you can definitely have some difficulties getting the buy-in of the senior management team. But when you start “operationalizing diversity” and place it into the priorities of the organization, you start to see results.

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## Closing the Diversity Leadership Gap: Easier Said Than Done

Despite strongly supporting the business case for diversity, respondents to Witt/Kieffer's recent Advancing Diversity Leadership in Health Care study felt neither the healthcare industry nor their own organizations had made significant progress in closing the diversity leadership gap. A follow-up to Witt/Kieffer's 1998 national survey on Diversity in Healthcare Leadership, the new survey was sent to 6,292 CEO, human resource, and minority executives in hospitals and health systems; 697 or 11 percent responded. Of that number, 71 percent were of the majority, 29 percent were minorities.

Seventy-nine percent of minority and 68 percent of majority respondents agreed that "Internal diversity programs are strategic to organizational success." Yet only 28 percent of majority respondents and 12 percent of minority respondents agreed that "Healthcare organizations have been effective in closing the diversity leadership gap over the past five years."

Even though nearly three-quarters of Caucasian respondents personally believed opportunities for diversity leaders have improved over the past five years, only 34 percent of minorities shared that personal belief. And although majority and minority respondents held widely divergent views on the most important barriers to diversity recruitment, retention and development, there was some general agreement that "Lack of commitment by top management" played a key role.

Written comments from the survey, as well as remarks from 45 respondents interviewed by phone, defined advancing diversity in leadership as a multi-pronged effort. Recommended approaches include:

- 1** Make diversity a strategic goal.
- 2** Establish organizational sensitivity.
- 3** Mentor minorities and provide opportunities for professional development including leadership training.
- 4** Promote from within.
- 5** Seek out young people graduating from high school and college to expose them to health care as a career.
- 6** Train students in healthcare graduate programs to be healthcare leaders, not just managers.
- 7** Provide internships/fellowships for graduate students in M.B.A./M.H.A. programs.
- 8** Find networking opportunities.
- 9** Commit to finding diversity leaders.

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