Savvy healthcare leaders recognize that diversity and inclusion is more than something “nice” to do; rather, it is essential to meeting an organization’s strategic goals as healthcare transitions to a value-based, patient-centered system that ties reimbursement to patient experience, population health, and patient outcomes.

To achieve these goals, healthcare organizations must develop a diverse and inclusive workforce and patient base to reflect the racial, ethnic, and cultural demographics of a community. They must also understand the unique needs of healthcare consumers in order to deliver equitable care.

In this HealthLeaders Media Roundtable, the panel discussed ideas, insights, and strategies on how a commitment to diversity and inclusion can translate into equitable care that positively influences clinical and financial outcomes, patient experience, and models of healthcare delivery.
HealthLeaders: What’s your personal definition of diversity and inclusion in healthcare?

Brenda Battle, RN, BSN, MBA: Diversity is really just all of the differences that are brought into the healthcare space. Some of those differences are related to long-standing cultural beliefs, and some are based upon intersecting diversity dispositions. For example, a person comes to the workplace and they’re a woman. They might be African-American, Asian, [or] white. They may have a [specific] religious background. Diversity is comprised in all those intersecting dispositions.

Inclusion is different to me because inclusion is how all those differences get recognized, how opportunities get created around those differences, and how individuals who bring all those differences to the workplace become a part of how the organization functions and achieves its goals. To me, the difference between diversity and inclusion is how it plays out.

Erickajoy Daniels: Diversity is just difference. It’s not a complex algorithm. It’s just difference that matters to people. That’s been important for us because sometimes people can infer that diversity means less than. That diversity means color. That diversity means underserved. That is a very small-minded approach to what diversity is.

Battle: And everybody is diverse.

Daniels: Exactly. When people ask, “Where are your diverse people?” the answer is “Everyone in the room.” Diverse people aren’t a certain background or a certain race or ethnicity. There’s so many differences about every one of us. When people understand they are part of this mix and that this work called diversity benefits them too, it changes the game. So, diversity is the difference that matters. The environment where that difference can thrive is the inclusive part.

Diversity and inclusion are parallel paths. You want to draw, attract, build, and identify difference. You want difference to thrive so people are fully contributing to and fully advancing the organization. And that’s a sweet blend.

John Hesselmann: Diversity is about bringing people of different backgrounds and perspectives together to “go to market.” It starts with the composition of your team and comparing that with the makeup of the client base. Inclusion is creating an environment where you strongly encourage different views and perspectives. You’ve got to be intentional in practicing inclusion.

HealthLeaders: Some of you have mentioned that equity also needs to be considered in diversity and inclusion work. Can you explain that?

Battle: Equity is creating opportunities for individuals based on their specific needs. It’s not the same as equality because I don’t need what you need; I need what I need.

Equity is how a healthcare system delivers care to patients in a way that meets the needs of those individuals based upon their background, their psychosocial disposition, what their needs are, and the resources they have in their environment. It’s how we make sure that individuals can be effective at what we expect them to do, which is to self-manage their care.

To me, the end goal of diversity and inclusion has to be equity for the individuals in the workforce, for healthcare [delivery], patient outcomes and experience, and the various metrics that healthcare organizations are tied to around improving health. If your diversity and inclusion efforts don’t result in equity across these various indicators, then it’s ineffective, in my opinion. I consider the order
to be equity, diversity, and inclusion. The goal is to promote and achieve equity.

Daniels: I think the same thing. People talk about gaps and voids in diversity part. You can’t go from diversity to equity; you’ve got to go from inclusion to equity. If you don’t do inclusion, you can’t create job and workforce opportunities or get good patient experiences

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and disparities. But equity is a positive view on what we’re trying to achieve for the patients we’re serving, the patients we’re seeking to serve, and the members of our care teams who are delivering that care.

Battle: And if you’re going to drive equity, you’ve got to do the or drive up the metrics for patient outcomes just because you have diversity.

HealthLeaders: How would you describe the current state of diversity and inclusion in healthcare?

Daniels: I think it’s in a place of evolving. I think people are level-setting and starting to understand what the terms diversity and inclusion actually mean.

Coming from the for-profit world, diversity and inclusion was a business decision because you go after who your consumer is. I’m learning it’s not as fully grounded in healthcare to see patients as consumers. I think that consumerism model is going to impact hospitals and healthcare systems and push them to understand that there’s an approach and opportunity that they may be missing.

Also, the nature of the world is changing. Many cities are becoming minority-majority cities. Healthcare is always going to be necessary, but it needs to attend to the individuals who are growing in our communities, so there’s got to be a shift. I don’t know that there was much of a press or urgency to do so before.

Battle: Healthcare has got some catching up to do. I’ve started up diversity and inclusion efforts now in two academic healthcare systems, both in St. Louis in 2006 and Chicago in 2012. I was one of the early pioneers with a few others who started in healthcare before me.

Healthcare has always had diverse consumers, but the healthcare industry has not thought about our patients as consumers. To appeal to our consumers, we’ve got to think about equity, diversity, and inclusion. These need to be a strategic imperative.

But now, the system is moving toward value-based reimbursement and population health management with hospitals being paid for value—outcomes at the appropriate cost without sacrificing quality. Value-based reimbursement requires the hospital to be responsible for patient outcomes regardless of where care happens. Another imperative for hospitals was the 501(r) Community Benefit law that said if you’ve got a not-for-profit tax status, you’ve got to show that you’re helping to relieve the burden of healthcare in your community.

I am happy that these imperatives have come along because now hospitals and healthcare systems have to pay more attention to what really improves outcomes for populations. It requires hospitals to understand populations from a cultural perspective, a lifestyle perspective, a socialization perspective, and to consider the influence of social determinants of health on populations. Attention to these factors is how we truly demonstrate and execute on equity.

Hesselmann: In many ways, healthcare and banking are similar. Who is our customer? It’s the same population. We would say that we work in communities across the U.S. to educate individuals and companies on financial wellness. In those same communities, you work with individuals to provide care on many levels, including their mental and physical wellness.

Since I started my career in banking, it’s always been about the client experience. In healthcare, the industry has more recently begun speaking about customer experience.

At our company, we had our first Global Diversity and Inclusion Council in 1993. That’s 25 years ago. We have things that we have to work on, but I’d say at our company specifically, diversity and inclusion have been embedded in our culture longer than in the healthcare industry.

Battle: Yes, it has. I can’t say I know anyone in healthcare that
has been doing diversity and inclusion since 1993. I started in 2006. In healthcare this represents a lot of experience in the space of diversity and inclusion.

HealthLeaders: What are some of the biggest pain points when it comes to furthering or building more diversity and inclusion?

Hesselmann: We would still say that we have underrepresented populations in our employee base. So, we’re kind of starting at the beginning and saying, “What do we need to do differently from a hiring standpoint?” We need to be a lot more creative about where we are looking for talent. Where we recruit is an example. If you look at our industry and pick one business—say, investment banking—there’s a historical profile of an investment banker; probably went to an East Coast school and in many cases Ivy League. Well, we have expanded the list to be more geographically and ethnically diverse.

You also need to consider the type of environment you are creating. We need to think about whether we’re creating an environment where young people will say, “Hey, I like what I see”; “I could fit in at Bank of America.”

You need to have executive leadership that’s open and encouraging of what you’re doing. I’m lucky because I have had managers who embrace diversity and inclusion. If you don’t have that support, I think it would make it very, very difficult.

Daniels: I would say breaking down defenses when trying to engage someone in a discussion and dialogue around why it could be or why it is a strategic opportunity. People will often say, “Well, we treat everybody the same. We are doing well. We are thriving.” That’s some of the defensiveness that can come up in a conversation around diversity and inclusion.

I also think one of the pain points is shifting people’s mentality around what it means. We had some of our earlier people say, “We’re going to do diversity and inclusion. We’re going to help poor blacks and Hispanics.”

Daniels: Yes. It is not me versus you. It is you and me.

Battle: Overcoming the fear that equity, diversity, and inclusion is extra work and won’t yield tangible results is a pain point that has to be overcome. Equity, diversity, and inclusion programs typically seek buy-in at the top and even down to the director and executive director levels. This is important and necessary. However, penetration at the middle-manager level often happens further down the line and sometimes long after the start of these efforts within the hospital or health system.

The greatest sense of creating extra work is often felt at the middle-management level because these working managers are busy balancing the day-to-day work. It’s because they’re the ones balancing the day-to-day work that equity, diversity, and inclusion programs need to build in processes that teach managers how to execute these strategies. Showing them how to include principles of equity, diversity, and inclusion into standard work in such a way that does not create extra work is imperative. When this group of leaders learns how to execute equity, diversity, and inclusion, the results will be manifested in the organization more quickly.

HealthLeaders: What are some of the arguments for making a commitment to diversity and inclusion? What should executives consider when making the decision to embed diversity and inclusion into their organizational structure?

Battle: I think executives need to consider who their customers are and what their customers want. They need to look at their mission, vision, and value statement honestly. Is the organization living...
these statements every day? They need to consider what outcomes they are trying to achieve.

What does the hospital or health system promise its customers or patients? What do you promise your employees? What is your organizational mission? Are you going to achieve it if you don’t include equity, diversity, and inclusion in your strategy? Hospitals between a patient and their provider, and that has a direct impact on their health outcomes, so think about service quality.

Those are just the common things that any organization is looking at to make sure they can be at the top of their game. If they’re doing it with equity in mind, they’re going to change their approaches and make sure finance, etc. The diversity and inclusion leader should sit in the C-suite where organizational strategies are determined.

The strategy has to have some resources committed to it. It has to be a part of the strategic imperative. You can’t just say it’s a priority but not put it in your strategic or annual operating plans. It has to be communicated and demonstrated from the top down. There needs to be an expectation that it is going to be tied to performance at all levels of the organization. There should be metrics and dashboards that reflect outcomes and stories.

Daniels: I totally agree. Visibility and accountability have got to come into play along with recognition for the work. You’ve got to recognize those who do it well. And share the stories—their’s so much anecdotal power that has to be relayed. You have to have the numbers, but you have to have the story behind the numbers as well.

Battle: And it should show up in your governance model. Your board should know that you’re doing work in this space.

Hesselmann: Leadership, accountability, and inspection.

**HealthLeaders:** What have you found to be best practices in diversity, inclusion, and equity work?

Daniels: Relationship-building is absolutely key to get any kind of space for influence. And authentic curiosity—asking as much as you can to understand. Because if you have relationships, both in the organization and in the community, then those people invite you to their game, too, which makes a world of difference.

Then making alignments as much as possible by connecting the dots for leaders who otherwise wouldn’t be doing it. Pace yourself to run with leaders instead of chasing people, because if you run with enough people, then the ones that you need to chase will end up looking up and asking, “What am I missing in the race?”

Your work is your constant work, particularly because in healthcare you’re working in the community, so while you’re engaging with the community you’re not turning it off. You’re informed, and people look to you and they know that you’re a leader in this work, whether you’re in the hospital or outside the hospital.

Battle: I would add to align equity, diversity, and inclusion with every aspect of your organization that you can imagine. How do we align equity, diversity, and inclusion with our ability to achieve regulatory compliance and national recognition like Magnet, Leapfrog, or U.S. News and World Report? How do we align it with performance metrics; business development and growth and population health management? How do we align it with employee engagement, patient satisfaction, and community benefit?

Hesselmann: I think our employee networks are a best practice. And, for myself, I have a monthly leadership meeting, and diversity and inclusion is a topic at each meeting. It may be presenting the diversity and inclusion plan for the year. It may be having the head of our employee networks on the call. It could be having an associate who gives their own testimonial on diversity and inclusion.

In our business we have a diversity and inclusion council that is diverse geographically, ethnically, and culturally. I meet with them every six weeks. I look to them for feedback and to be diversity and inclusion champions within the business and their teams.