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Why Board Diversity Matters

Practical ways to meet the varied needs of your community
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Take a look at your community. Now, take a look at your board. Does the hospital board reflect your patient base? Ideally, board membership should mirror the community it serves. Yet overall, American hospital boards remain well behind the diversity of the U.S. population: just 12 percent of board members are non-white, while the 35 percent of Americans belong to ethnic minorities.

Among hospital patients, the gap is even greater because more minorities end up in the hospital. "Ninety percent of the people who serve on boards are white, but around 40 percent of the patients we serve are white," says Frederick D. Hobby, president and CEO of the Institute for Diversity in Health Management, an affiliate of the American Hospital Association. "We've got some rebalancing to do."

Because the board is the most public face of the hospital or system, it's vital that those individuals look like the people who are being served, diversity advocates argue. Not only does the community relate better to the institution, but the hospital has a greater chance of understanding and meeting the needs of its patient population, Hobby and others say. "The importance of having a diverse board is really to be able to provide the kind of leadership that results in culturally competent care," Hobby says. "The better we do that, the greater likelihood of having high patient satisfaction, fewer quality issues and a board that reflects its community's values and needs."

For the organization, diversity is a direct link to a number of strategic goals, most obviously patient satisfaction. Trustees with connections to specific community

subpopulations also can help identify their medical needs, helping the hospital pinpoint new, productive lines of business.

Organizations whose strategic goals include reducing disparities in the provision of medical care will have a leg up in making progress on that issue in their communities. "If there are minorities on the board, then perhaps there will be a champion who will be providing guidance to the leadership that the organization needs to collect data and compare that data across gender, ethnic and age categories as a first step in identifying and eliminating adverse medical outcomes," Hobby says.

That's not to say that nonminority trustees can't do the same thing, he adds. "If they have a sense of awareness that there are unique characteristics and disproportionate health issues in various diverse communities, and if they have a sense of equity or social justice, then they can be just as effective as minorities on these issues," he says.

In fact, Hobby recommends to minority board members that they not become "lone rangers" for their community's issues and instead partner with nonminority trustees to be most effective in gaining support for initiatives that interest them. "There's nothing less credible than having an ethnic member or gender member on the board whose only contribution on the board deals with the issues that face their own communities," Hobby says.

Sharon Rossmark was recruited as a minority trustee for Sinai Health System in Chicago. She brings 30 years of business experience in the insurance industry and her own life experience to the table. "It all plays into the decision-making of the board," she says. "It allows us to have a broader and richer conversation than if we focused on one type of background."

An Expansive Definition

While diversity often is seen as a question of white, black and brown, there are many other types to consider when recruiting board members. For example, achieving gender diversity continues to be a challenge for boards and upper management.

A hospital governance survey found that women have made strong gains in the ranks of hospital boards. A 2009 report from the Center for Healthcare Governance, an AHA affiliate, found that 24 percent of board members were women.

There's also diversity of religion and sexual orientation. Gay, lesbian and transgender communities have specific needs in medical contexts that board representation can help address. "You may have a visitation policy on the books that says only family members and spouses can visit after 8 p.m.," Hobby notes. "What about the woman whose significant other is another woman and is the caretaker? If you have a gay woman on

the leadership team, she might raise that issue because she is aware of it in her community."

While it's important to look broadly for groups with specific needs, in many communities, racial and ethnic diversity remain top priorities for boards. "If you're running a hospital in San Francisco and have a large Chinese population, you should have a Chinese businessperson or educator on your board," Hobby suggests. "You need someone who can help you understand the cultural beliefs and practices of that community and someone who will be an advocate so that the services you provide will be in their language."

The first step in understanding the ethnic and racial groups that should be represented on the board is to research the organization's patient population, a form of marketing work that is basic to most hospitals.

"The more we know about the patients we serve, the better we can reflect the profile on the boards," Hobby says.

Finding and Approaching Candidates

Hospitals seeking to expand board representation of various subpopulations often say they can't find candidates, diversity advocates say. That may be because they're using the same recruitment method they've always used, which is usually word-of-mouth through the current board and executive staff and their colleagues, families and neighbors. Some boards may go further and contact major civic organizations in the communities they want to reach, only to find that those leaders already are busy with governance obligations for other organizations and philanthropies.

Mary Medina hears this all the time. As executive director of the Center for Trustee Initiatives and Recruitment for the Greater New York Hospital Association, which sponsors one of the nation's leading programs advising hospitals on diversity in executive leadership and boards, Medina's advice is to go beyond the usual networks. She suggests tapping up-and-coming community leaders in less visible organizations, and those who are not yet in leadership positions but are active and have the appropriate experience. "Get to know the leaders in those communities," she says. "It may not be the person who is identified as the leader. It may be the next level down of emerging leaders.

"One of the best pipelines for me is professional organizations," she adds. "Each one has a chapter in your region, and you have engineers, finance and accountants, lawyers, construction managers. I've gone to their meetings and presented what we're doing. You'd be surprised by the number of senior-level managers who've never been asked to be on a board."

Instead of waiting for a crisis to make contact with minority communities, Medina suggests a thoughtful, long-term approach that identifies goals for the communities with which the hospital wants to connect, possibly to provide targeted medical services as a business strategy. Start by establishing relationships with trade and professional associations and local business and community leaders. Part of that process is educating the community about the hospital and about what governing boards do, she adds.

It's important to make a good match for the potential trustee so he or she wants to stay on the board. Medina suggests offering committee assignments that are interesting to the recruit.

Finally, be up front about whether there is a philanthropy component to the trustee role. If board members are expected to contribute or raise money, approaches to philanthropic work may differ by culture, she notes.

Unique Sources

Recognizing the difficulty of changing long-standing recruitment patterns, the Institute for Diversity in Health Management and the Center for Healthcare Governance established an online registry of qualified minority board candidates. **[not functioning in June 2018]** The list includes nearly 300 people from around the country, all of whom have taken the Institute's trustee training course.

Antoinette "Toni" Waller was one of the first placements from the registry. She is CEO and administrator of CareCollaborative Home Health Services in Chicago and serves on two boards: the Catholic Health Initiative corporate board, Denver; and Alegent Health, Omaha, Neb. Waller was the first African-American female appointed to the CHI board, which is a large faith-based health care organization operating in 18 states with 73 hospitals. She was approached by Kevin Lofton, CHI CEO and former AHA chair, sought out primarily for her nursing experience; her cultural background was an extra, she said.

She sees both as attributes that help her as a trustee. "I bring all of that to the table," she says. "The work I currently do in my profession is working in a very diverse community and being culturally competent in the care that's needed."

Her role on the board is the same as any other trustee in terms of health care expertise. But she also is able to pursue questions of cultural competence. "It's good to be able to challenge the board. 'Have we really done this work? Have we really reached deep enough to answer the questions the communities are asking of us?'" Waller says. She's particularly interested in the organization's work on racial and ethnic disparities in the delivery of medical care.

Further placements from the institute's list of potential board members have been slower than Waller would like, she says. "Even though we have more than 200 candidates on our roster, only 11 of them have been placed, which is not a good thing," she says. She'd like to see the list, set up in 2008, become more visible to hospitals recruiting new members.

The training program has been a learning process both for the trustee candidates and the AHA affiliates involved, says John Combes, M.D., president and chief operating officer of the Center for Healthcare Governance. "Many of the candidates in that room know a lot about governance and about health care," Combes says, "not necessarily hospital-based health care, but community-based health care and other social service agencies."

From the health system perspective, recruiting for the board can be challenging because many of the most qualified people are in high demand and busy with their own careers. CHI, for instance, has trouble finding candidates younger than 50 because they don't have time to sit on a national health system board. "Many times people will say to me, 'I would like to serve, can you come back to me in two years?'" says Sister Peggy Martin, CHI senior vice president for sponsorship and governance. She finds many recently retired people are ready for a trustee position.

The organization continues to seek a variety of board members by race, ethnicity, gender and age. "You really miss opportunities and knowledge if you don't have diversity," she says. "It also fits into our core values of reverence, integrity, compassion and excellence."

Raising the Issue

Raising questions about the level of diversity in leadership and on the board can be uncomfortable, Medina says.

Her suggested list of questions (see box on page 38) includes a realistic appraisal of whether it's the right time to increase diversity. "This may not be the right time, but you should have this conversation sometime," she notes. Otherwise, the choice may be out of your hands if community members or legislators decide the hospital's leadership is not representative enough. "If you do not have the conversation on your timetable, you will have it on someone else's timetable," she says. "Either you set the agenda and control it or, I can assure you, there will be other people who will bring this conversation to your table."

She advises talking about the issue once or twice a year, working through the nominating committee.

Having diverse faces on the hospital board is only one part of an overall diversity strategy, Medina adds. It's also important to open the ranks of upper and middle management to qualified minority candidates, and the organizations that do that often are those with a good mix of backgrounds on their boards.

To that end, the New York hospital association runs two programs to train and encourage minority leadership candidates. One is for graduate students from diverse communities who are partnered with a mentor; the second works with middle managers who have been in hospitals for five or more years and have not yet been promoted. They learn what it takes to run an organization and how to get to the next level.

According to the Institute for Diversity in Health Management's Hobby, the number of racial and ethnic minorities in leadership positions at hospitals was about 2 percent in 1994 and has grown to 8.5 percent today.

"We've made tremendous strides considering the historical background of segregated hospitals and physicians of color not being able to practice in major teaching hospitals," he says. "It wasn't that long ago that these hospitals had no minorities in their leadership ranks."

Hobby believes active diversity programs are growing slowly, and the hospital industry's progress falls into a few general categories. "About 1,000 are doing great, innovative work in diversity management and cultural competency," he estimates. "There are probably another 1,000 to 1,500 that are in between—not leaders but are developing cultural competency programs to provide better care for their patients."

But there are many other hospitals not doing much at all, he says. It requires active programs to make boards and top management of organizations reflect their communities.

"We're not at the tipping point by any means," he says. "We're in the embryonic stages of managing diversity programs in health care. In the private sector, corporate America started this back in the 1960s and early 1970s. Most of us started this work in the 1990s."

Meanwhile, American communities are changing rapidly. U.S. Census data suggest that ethnic minorities will be the majority of the population by 2050.

Adapting to changing demographics is good business for hospitals. "The customers are going to become more and more diverse," Hobby says. "Smart hospitals are learning to manage that diversity and use it to create a strategic business advantage."

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Putting Diversity on the Agenda

Trustees should examine their board's diversity once or twice a year, according to Mary Medina, executive director of the Center for Trustee Initiatives and Recruitment for the Greater New York Hospital Association. She suggests using the following questions as a starting point:

- What is your current board composition?
- What has kept your facility from adding diverse members to the board?
- What value do you believe diverse candidates can bring to the board?
- Is it the right time to add diverse members to your board?
- What would the board need to work well with diverse candidates?