

Executive Summary

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Disparities Leadership Program
Empowering Leaders. Getting to Solutions.



Presented by



**LEADERSHIP LEARNING
COMMUNITY**

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Disparities Leadership Program Executive Summary

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Introduction

The Disparities Leadership Program (DLP) is designed to equip a cadre of leaders in healthcare with in-depth knowledge of the field of disparities, cutting-edge quality improvement strategies for identifying and addressing disparities, and the leadership skills to implement these strategies and facilitate organizational transformation towards greater equity. This program is funded and offered by the Disparities Solution Center (DSC) of Mass General Hospital (MGH) in Boston, MA. To date 130 people have participated in the DLP from 89 organizations, representing 28 states, along with the Commonwealth of Puerto Rico and Switzerland. Forty-four participating organizations (44) have been hospitals while the others were health plans and community based organizations.

The DLP is a one year executive leadership program that begins with a formal skills curriculum delivered during a two-day face-to-face intensive training session. DLP teams bring with them a well-thought out plan or proposal for advancing disparities work in their organization as well as the support of senior leadership from their organizations. Technical assistance is provided through three interactive web-based conference calls for the group, and two interactive web seminars on additional learning topics tailored to the most pressing needs of participations. In addition, participants receive real-time assistance through one-on-one coaching calls. Participants are also invited to participate in other DSC activities. Three quarters the way into the year (at month 9 of the program), the DLP has a two-day meeting where participants present their work and lessons learned. The DSC offers an innovation award for selected projects and the opportunity for award winners to present their work at national forums and conferences.

With support from the Aetna Foundation, the Disparities Solutions Center contracted evaluators from the Leadership Learning Community to conduct an external assessment of DLP and its impact. Participants in the study included all organizational teams that participated in the program from 2008-2011. The study design was approved by the MGH IRB in April 2012, and data was collected from May 2012 to December 2012. Data sources included an online survey, key informant interviews, and case study site visits.

This executive summary provides an overview of key findings, conclusions, and recommendations. Evidence for key findings can be found in the quantitative and qualitative summaries as well as the case study descriptions attached to the executive summary.

Key Findings

The key findings are clustered around four impact domains: DLP alumni, DLP network, DLP Project, and Organizations and Healthcare Systems.

DLP Alumni

Overall, DLP alumni report that they are much better prepared to identify and address racial disparities than they were before the DLP. They are also more aware of why disparities work is so important for making progress on health systems reform and achieving health equity.

DLP alumni reported significant knowledge gains in how to identify racial/ethnic disparities and use tools like dashboards, registries, and reports. They also report greater capacity to establish a sense of urgency, create a shared vision, secure leadership buy-in, and integrate disparities priorities in their organizations' strategic plans. There were some notable differences in knowledge gained across classes, with the 2010-2011 class generally showing higher perceived knowledge gain, followed by the 2011-2012 class. These higher knowledge gains in later years of the program may indicate the DLP's increased capacity to build participant knowledge and skills as the program undergoes continuous quality improvement every year. Having only graduated the month prior to participating in the evaluation, it is still too early to fully assess the gains made by the 2011-12 participants. Since knowledge gain is correlated with the ability to apply what you have learned, a better assessment of their growth will be further down the road.

Nearly 75 % of DLP alumni report gaining a new vision of their role as healthcare leaders. They have become more passionate advocates for eliminating disparities and more confident in their ability to lead this work. Their credibility for leading efforts to reduce disparities in their organizations has been enhanced through participating in the DLP and their effectiveness and visibility has increased by being part of the DLP peer network. Several organizations are nationally recognized for their leadership.

Having participated in the DLP prepared me to feel more confident in facing organizational challenges. I feel I can speak with more authority than before. Where I've grown as a leader, we've been faced with all kinds of challenges, and we have met most of them successfully, that's led to my growth and how I manage these challenges.

Participant class of 2008-2009, Hospital Leader

DLP Network

The DLP peer network is highly valued by DLP alumni. Two-thirds of alumni report that they have a network of mentors and colleagues that can support their future work in this field. Being part of a peer support network has provided encouragement, validation, and useful advice to alumni, helping them further their skill development, feel less isolated and reaffirming their determination. DLP alumni provide useful and valuable assistance to each other by sharing resources, ideas, and tools and assisting each other to make a better case for organizations to invest in disparities work.

When we were trying to get enthusiasm for a budget to hire interpreters, I knew a person from Virginia in my cohort had done this so we invited her to visit. She came up for a day and told us how they measured the value, etc. When we started to hire managers and job descriptions, we called others about how they marketed for this kind of person.

Participant class of 2008-2009, Hospital Leader

DSC faculty and staff provide on-going support to organizations during and after the DLP program. The DSC stands as a model for other hospitals in the field because of Massachusetts General Hospital's achievements in identifying and addressing racial and ethnic disparities in health care. Their passion, commitment, and credibility have made it easier for organizations to take on this work and develop their own programs. Alumni value the relationships they have formed with the DLP/DSC staff and faculty.

What has been valuable for me is the networking that came out of it. Being able to tap amazing expertise at the DSC (Joe, Aswita, Roderick) to help guide program development in an advisory role. They have very graciously done so much to promote the greater good.

Participant class of 2008-2009, Health Plan

Despite the value of the DLP network, alumni state that it is a challenge to be able to take full advantage their expanded network of peers. Alumni are more likely to benefit from relationships they developed with people in their cohort. Accessing knowledge from other cohorts is less likely, although alumni conferences and webinars have provided access for some. Some people could not afford to travel to attend the DSC's HealthCare Quality and Equity Action Forum in September 2012 and some are unable to attend webinars when they are offered. Expanding the platforms for alumni to access each other's knowledge and support is important for leveraging the full value of the network. Expanding access to the peer network would allow alumni to further share tools, research, and strategies for improving health outcomes of all people.

DLP Project

Alumni highly valued the design and structure of the DLP project component because it helped them focus, stay on track, and build momentum for what they were trying to achieve.

Because it was a year-long program, the time limits and the program structure made me crystallize my focus. When I entered the program I knew that I also had to build our interpreter services and I easily could have been pulled into doing this work and many other priorities rather than the REAL Data Project. DLP made me take this project on. I really don't think we would have done it as well if we had not been in the program.

Participant class of 2009-2010, Hospital Leader

DLP offered me easy milestones and rest points in completion of my project. Because working on the project wasn't my only project, it gave me an opportunity to really sit with accomplishments and strategize how to elevate the work among our leaders.

Participant class of 2011-2012, Hospital Leader

Projects achieved a number of goals, such as:

- Obtaining leadership buy-in and incorporating health equity and eliminating disparities into organizational missions and strategic plans;
- Establishing new offices and leadership positions, increasing staffing, and forming cross-department equity councils that meet regularly;
- Improving data collection systems and increasing the capacity to collect and stratify data by race and ethnicity;
- Improving training programs to educate staff, the C-suite, and clients/patients about (1) access, quality and the importance of eliminating disparities; (2) diversity, inclusion, and cultural competency; and (3) the nuts and bolts of implementing registration or interpreter services systems; and
- Changing how programs are designed and marketed and recognizing the importance of engaging patients and community organizations in making campaigns effective.

Areas where progress has been slower include analyzing new sources of data that is being collected and implementing new interventions to close disparities gaps. Despite the fact that few organizations so far have achieved the goal of impacting health outcomes by the changes they have made in systems and training efforts, the DLP participants are at the leading edge of addressing health equity in the country. They

have modeled the early and intermediate steps few organizations have taken in the country.

Organizations and Healthcare Systems

On average alumni reported that their organizations increased their awareness of disparities and are more supportive of efforts to identify and address disparities than before DLP. Their organizations have assigned leadership responsibility for addressing racial/ethnic disparities and have enhanced their systems for collecting racial/ethnic data from patients/members. Many organizations are still in the planning stages for reporting quality measures by race and ethnicity, deploying interventions, and assessing outcomes in quality/safety meetings and rounds. Almost all organizations measure patient/member satisfaction and nearly 75% collect HEDIS measures.

While the DLP has focused primarily on building team capacity and organizational change, initiatives are starting to emerge that involve cross-organizational partnerships that have the potential to expand the research evidence for addressing disparities and better integrate systems to support access, quality improvement, and greater health equity.

For example, two hospitals are piloting a program, TeamSTEPPS, to help improve patient safety among those with limited English proficiency. Given the DLP's extensive network, the DSC was in a unique position to identify and broker this research opportunity, which made this an attractive opportunity for the funder of this project. The process and results of this pilot have been shared in a webinar so other hospital systems can learn the process and take steps to implement changes in their own institutions.

Another area with the potential to significantly improve the capacity of the healthcare system to address disparities is the partnerships that are forming between health plans, hospitals, and community health centers to more closely integrate and align their joint efforts. For example, Alameda County Medical Center (ACMC) is partnering with Kaiser Permanente to train ACMC's bilingual staff to become interpreters.

A third area where DLP organizations have partnered is in efforts to collectively lobby developers of electronic medical records systems to make sure they are designed in a way that facilitates the collection and stratification of race/ethnicity data.

This evaluation uncovers some of the outcomes the DLP has had at the individual, organizational, and health system level. Below are some recommendations that may help maximize the impact as the program moves forward.

Recommendations

Expand the participation of health plans and community health centers

Hospitals are four times more likely to participate in the DLP than health plans and community health centers. With small numbers of health plans and health centers, some organizations missed an opportunity to interact and learn with peers from their own type of organization. Hospitals, health plans, and community health centers bring different perspectives and experiences to the program that are highly valued and rare to find in day-to-day interactions. The rate limiting factor for participation of community health centers seems to be cost and limitation of human resources; no particular rate limiting factor has been determined for health plans. Scholarships for community health centers, public hospitals, and Medicaid managed care plans have been very helpful to increase participation of these organizations in the DLP, but additional funds may be required to support travel and other related expenses.

Adapt the curriculum and connect participants to outside resources

DLP alumni mentioned several areas in which they would like more learning support, including how to prepare for and increase workplace diversity and staff retention; how to improve the interpersonal and communication skills needed to do this work, especially around issues of race, racism, and disparities; and how to negotiate and manage conflict.

Perhaps the curriculum can also be adapted to accommodate the varying needs of those in the class. Since people come into the class with different levels of knowledge, they may need different supports. When the curriculum is driven in part by the needs of the particular class, they are more likely to get their needs met. Of course, there are limits to what can be covered in a year-long program, and some resources can be accessed elsewhere. Identifying external resources on critical issues for making organizational change and connecting those in need of these resources might add significant value beyond what the DSC can provide directly.

Increase the capacity of the network to be a resource for each other

The hub of the DLP network is the DSC faculty and staff, with Dr. Joseph Betancourt repeatedly being mentioned as a critical ally and supporter for helping organizations advance their disparities work. Alumni also expressed an interest in having more access to each other as resources through a more active listserv or other web-based platforms. Developing tools and processes to increase the network's capacity to find resources and make connections without having to go through DLP faculty and staff will strengthen network resilience and grow its influence. DSC faculty, while highly devoted

and committed to supporting organizations, have limited capacity when compared to the resources of the network as a whole. Maximizing access to those resources should be a priority in the next five years.

Expand post-program supports

The work of eliminating disparities and achieving health equity in complex health systems is a long journey fraught with many opportunities and challenges. The DSC-sponsored Healthcare Quality and Equity Action Forum is highly valuable for those who have the time and resources to participate. Given a lack of institutional resources especially among those that serve the most vulnerable populations, more attention needs to be paid to how to make conference sessions, webinars, alumni activities, and other materials available to teams when they have time to access them. Community of practice groups organized around critical issues like data collection strategies or community engagement strategies might offer a forum for participants to share approaches and get advice.

Conclusion

The Disparities Leadership Program has been a key factor for health plans, community health centers, and hospitals to make progress on identifying and addressing disparities. It has provided the focus, structure, and support that organizational teams needed to take make strides forward. The DSC faculty and staff are highly regarded by those in the program for their passion and commitment and for what they have achieved and model for others. They have provided unwavering support to DLP alumni and their organizations.

Significant progress is being made by DLP organizations to integrate health equity into their strategic plans and to develop systems to collect race/ethnicity data. Most organizations have not yet reported eliminating disparities (the Neighborhood Health Plan case study is an exception) because many are just now getting to a place where they are collecting quality data and have the organizational buy-in to stratify and use the data.

With recent passage of the Affordable Care Act and other initiatives to improve quality and access to care, DLP alumni are well-positioned to champion and lead change in their organizations at a time of rapid change. The DLP network will continue to be a valuable resource to all who are committed to achieving health equity. Weaving and nurturing the network and celebrating and promoting the accomplishments that organizations achieve should be a DSC priority in the coming years.

By continuing to explore the potential for cross-system collaboration and alignment among DLP alumni organizations, the influence of the DLP network on the field will grow and increase its potential to achieve sustainable changes in quality and access for all patients.