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ANALYSIS & COMMENTARY

Organizational Change Management For Health Equity: Perspectives From The Disparities Leadership Program

ABSTRACT **Leaders of health care organizations need to be prepared to improve quality and achieve equity in today's health care environment characterized by a focus on achieving value and addressing disparities in a diverse population. To help address this need, the Disparities Solutions Center at Massachusetts General Hospital launched the Disparities Leadership Program in 2007. The leadership program is an ongoing, year-long, executive education initiative that trains leaders from hospitals, health plans, and health centers to improve quality and eliminate racial and ethnic disparities in health care. Feedback from participating organizations demonstrates that health care leaders seem to possess knowledge about what disparities are and about what should be done to eliminate them. Data collection, performance measurement, and multifaceted interventions remain the tools of the trade. However, the barriers to success are lack of leadership buy-in, organizational prioritization, energy, and execution, which can be addressed through organizational change management strategies.**

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Despite the uncertain future of the Affordable Care Act (ACA), the US health care system is moving steadily toward maximizing value in the delivery of services. Driven by payment reform—shifting away from paying for quantity to paying for quality of services—the aim is to deliver care that promotes clinical effectiveness, efficiency, and affordability. For example, the Centers for Medicare and Medicaid Services (CMS), by way of the Medicare Access and CHIP Reauthorization Act of 2015, has implemented the Quality Payment Program for Medicare, which will link clinician payments to quality and value.[1] This builds on CMS's accountable care organization efforts, which drive toward value by creating contracts with providers that share financial risks and rewards, including through efforts in population health for diabetes and other chronic conditions.[2] At the state level, the Medicaid waiver program, and California's Delivery System Reform Incentive Program in particular, have pushed the use of payment reform to improve quality, control cost, and achieve value.[3] Commercial insurers across the nation are also advancing value-based or alternative care contracting to improve quality and control costs.[4]

Rooting out waste, variations in care, and inefficiencies that lead to poorer health outcomes is a key part of this effort, as are strategies to ensure that care is safe, efficient, effective, timely, patient-centered, and equitable—the hallmarks of quality.[5] Yet today members of racial and ethnic minority groups often receive lower-quality health care, compared to their white

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counterparts—even those with the same insurance and socioeconomic status, and even when comorbidities and other confounders are controlled for.[6–8] These disparities in care, which infringe directly upon the principle of equity in quality, are multifactorial in nature, contribute to poorer health outcomes, lead to higher costs, and exemplify low-value health care.[7–9] To be successful in an evolving health care environment focused on value, and in the context of disparities and an increasingly diverse population, leaders of health care organizations must be prepared to improve quality and achieve equity.

The Disparities Leadership Program

To help prepare leaders for this challenge, the Disparities Solutions Center at Massachusetts General Hospital launched the Disparities Leadership Program in 2007.[10] The leadership program is the nation's first and only ongoing, yearlong, hands-on executive education initiative aimed at bringing together and training leaders of hospitals, health plans, and health centers from across the country to improve quality, eliminate disparities, and achieve equity in pursuit of value. The program aims to arm health care leaders with an understanding of the causes of disparities, focusing on high-cost, high-risk areas such as improving population health and preventing readmissions; help leaders create strategic plans or projects to advance their work in reducing disparities in a customized way, with practical benefits tailored to each organization; and align the goals of health equity with those of health care reform and value-based purchasing, promoting the organizational changes necessary to exceed quality standards and regulatory requirements for care.

The Disparities Leadership Program consists of three major training activities for teams (each comprising one to nine members) from each participating organization, which commit to creating an organizational strategic plan to address disparities or carrying out a disparities elimination project. The first of these training activities is an initial two-day intensive training session in Boston, Massachusetts, focused on defining disparities and root causes; developing cutting-edge quality improvement strategies to identify and address disparities; and fostering leadership and change management skills to implement these strategies and help transform participants' organizations. The second activity takes place as teams work in their home locations to achieve their disparities project goals. Teams receive year-long assistance consisting of three interactive conference calls for collaborative groups (comprising several teams from organizations that are brought together for learning and support), two interactive online seminars on additional learning topics chosen to address the most pressing needs of the participants (such as how to develop a disparities dashboard that reports on quality data stratified by race, ethnicity, and language), and two technical assistance calls per organization. The third activity is a closing meeting in Santa Monica, California, at which participants present their work and lessons they learned from their strategic plans or projects and receive additional skill-building assistance and training on organizational change management strategies.

In addition to undergoing a formal, external evaluation at its five-year mark, the leadership program has undergone yearly assessments since its founding, based on survey data from the participating organizations. These assessments have identified the challenges that health care leaders have faced in their attempts to address disparities, and the factors that were critical to their success. This article provides an overview of these findings, focusing specifically on how organizational change management strategies, as identified by participants, can accelerate efforts to improve quality, address disparities, and achieve equity in pursuit of value. Organizational change management is a framework for managing the effect of new business processes, changes in organizational structure, or cultural changes within an enterprise.[11] While the framework has not typically been applied to efforts to achieve equity in health, our findings highlight how these organizational change management strategies are exactly what is needed, called for, and desired by those engaged in disparities reduction efforts.

Study Data And Methods

PARTICIPANT CHARACTERISTICS In the period 2007–17, ten cohorts of participants in the Disparities Leadership Program have come from 127 unique organizations located in thirty-one states, Puerto Rico, Canada, and Switzerland. (A flow diagram showing the relationships of organizations, teams, and submitted surveys is provided as online Appendix Exhibit A1.)[12] Because our tenth cohort was still participating in the program at the time of our research, we analyzed nine years of survey data from 115 organizations. Given the consistency of survey responses over these nine years, it is unlikely that the tenth cohort's responses would differ significantly from those of previous years.

Before performing qualitative analyses, we excluded the responses of thirteen organizations

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that were not hospitals, health plans, or community health centers because they had significantly different organizational structures than most of the other participants. Among the excluded organizations were hospital and medical interpreter associations, CMS, disease-specific organizations such as the American Cancer Society, a medical school, a correctional health facility, a public health department, a state health care quality improvement program, a health policy institute, and a pharmaceutical company. Five organizations did not compete surveys. As a result, our sample consisted of survey responses from 97 unique organizations that participated in the program in the period 2007–16.

Our unit of analysis was the surveys completed by the teams from each organization. Each team was asked to complete one survey at the end of its program year. Twenty-two of the 97 organizations subsequently sent an additional team for training, resulting in a total of 119 teams and an equivalent number of completed surveys.

SURVEY PROCEDURE At the conclusion of each twelve-month training session, participants completed a survey consisting of eight open-ended questions that focused on their perceptions of the impact of the program on their organizations' focus on equity (for the questions, see Appendix Exhibit A2).[12] The questions covered the following six domains: skills and knowledge participants gained from the program; participants' progress on their disparities project or organizational planning efforts; the overall impact of the program on participating organizations' capacity to better plan for, identify, and implement models to identify and address disparities; impact of participation on organizational restructuring focused on equity improvement efforts; impact of participation on networking or development of collaborative relationships inside and outside of participants' organization; and ways to improve the overall quality of the program.

DATA ANALYSIS We analyzed 119 surveys that represented 97 unique organizations and 269 participants. We used a sequential grounded theory approach in our analysis, beginning with three of the authors reading the survey responses independently and identifying main domains.[13] Subsequently, the three authors met and discussed domains, drawing connections between them and modifying domains through discussion until arriving at consensus. This process was repeated using small samples of completed surveys until no new domains were identified by the authors—at which point, thematic saturation was achieved. The finalized thematic framework was found to be similar to that of organizational change theory.[14–16] Using this framework, two of the authors manually coded all of the remaining survey responses.

LIMITATIONS There are several limitations to our study. First, our sample is not likely to be representative of all health care organizations. Organizations participating in the Disparities Leadership Program have already made a certain level of commitment to health equity work, given the monetary, staff, and time commitments needed to participate. However, this is also a strength of the study because the data highlight the unique facilitators and barriers organizations face as they prioritize a health equity focus. In addition, ours is the first national study of the experiences of a large and diverse sample of organizations implementing health equity strategies.

Second, our survey was administered at the end of a year-long program. This timing may have introduced social desirability response bias, because participants may have wanted to present a more favorable perspective on their experience than they actually had. However, the surveys are completed at the conclusion of the program, which is when participants are asked to plan for and think about the future of the equity work. This likely allowed for participants to be highly motivated and reflective about how to encourage and implement further health equity work in their organizations.

Finally, as a unique exploratory study, our analyses are primarily hypothesis generating and will need replication in a larger and more representative sample of health care organizations to determine whether our results apply to organizations not participating in the Disparities Leadership Program.

Study Results

THEMATIC ANALYSIS Five major domains or overarching strategies emerged from our survey analysis: know who to involve; shape organizational culture; create urgency and a vision and make the rational and emotional case; engage your organization and your audience; and harness the power of a collaborative network. An additional twenty-seven subdomains emerged from these five domains (Exhibit 1).

ILLUSTRATIVE QUOTES FROM SURVEYS Below we briefly discuss the major domains extracted from participants' responses and present illustrative quotes for each domain. A more detailed presentation is available in Appendix Exhibit A3.[12]

▸ **DOMAIN 1—KNOW WHO TO INVOLVE:** This domain primarily emphasized the importance of engaging leadership as well as midlevel and front-line staff, and the challenge of leadership

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EXHIBIT 1

Five major domains of responses to the Disparities Leadership Program (DLP) surveys

Domains	Subdomains
1. Know who to involve	Leadership buy-in; engagement and organizational buy-in; leadership turnover; engagement and having the right people at the table
2. Shape organizational culture	Structural changes in the organization; competing priorities; raising leadership and organization awareness of disparities, building the case, and increasing understanding of disparities in health care; gaining credibility through participation in the DLP; organizational commitment and integration of disparities through participation in the DLP
3. Create urgency and a vision and make the rational and emotional case	Understanding or awareness of disparities within the organization; linking disparities to quality; integrating disparities work into existing work; dissemination of disparities work and developing a communication strategy
4. Engage your organization and your audience	Internal partnerships; external partnerships; branding and strategic marketing; leveraging awards for creating awareness in the community; networking, peer support, and the DLP alumni network
5. Harness the power of a collaborative network	Leveraging regulatory incentives or drivers; sharing resources, tools, best practices and case studies; technical assistance, expertise, and monitoring; professional development; dissemination and exposure; benchmarking with other organizations; leveraging the DLP award; leading change strategies; participation of multiple teams from the same organization to help move disparities work forward

SOURCE Authors' analysis.

turnover in the process of making equity a key component of the organization's work and mission.

One participant said, "The biggest challenge we faced with buy-in amongst our executive leadership was framing health care disparities in such a way…that they placed it as a priority amongst all of the other competing priorities and allocated the proper resources to make our initiative a success."

Another noted that "our working team…comprised diverse members across various race[s]/ethnicities, geographies, age, gender, position/title, and department. This diversity contributed to the most innovative brainstorming I've had the honor to lead which, in turn, eventually developed into our fresh and innovative strategies."

▸ **DOMAIN 2—SHAPE ORGANIZATIONAL CULTURE:** This domain primarily emphasized internal organizational cultural barriers to equity, such as competing priorities and lack of buy-in and awareness of disparities. Ways to facilitate equity included aligning it with organizational priorities through increased awareness and integrating efforts to reduce disparities into the organization's mission.

"Participation in the DLP has increased awareness of racial/ethnic disparities within some areas of leadership in our organization," one participant reported. "Since our chief clinical officer was a participant, she has continued to champion the equity initiative. Her participation also prepared her and positioned her to insert 'addressing disparities' into [our] 3-year quality strategic plan."

Another said: "We have employees who really want to do the right thing for our members. The culture [of the organization]…was instrumental in our developing buy-in at all levels."

▸ **DOMAIN 3—CREATE URGENCY AND A VISION, AND MAKE THE RATIONAL AND EMOTIONAL CASE:** This domain primarily highlighted the importance of creating urgency for equity-related efforts by grounding efforts in a vision and communication strategy that allowed the integration of efforts to address disparities into the core work of the organization.

One participant reported that "once the analysis [of data] was distributed, it was underestimated how many times and [in how many] different ways the message of health equity had to be reiterated across the entire health system. This put a crunch on our timeline for completion of the health equity forms that were required."

▸ **DOMAIN 4—ENGAGE YOUR ORGANIZATION AND YOUR AUDIENCE:** This domain illustrated the importance of engaging and partnering with key stakeholders. This includes internal partnerships across the organization, as well as external partnerships with stakeholders in the community.

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"Our organization regularly participates in community events targeted to reach the Native American population of New Mexico," one participant reported. "We took advantage of a planned community event (Native American Health Services booth at NM State Fair) to conduct a survey on Native American attitudes towards and knowledge about diabetes. Additionally, our Native American Health Services office interfaces with Native American Community Health Centers throughout the state and has access to contacts in those locations whom we can tap for diabetes outcomes information and education materials."

▶ **DOMAIN 5—HARNESS THE POWER OF A COLLABORATIVE NETWORK:** This domain underscores the importance of being a part of a collaborative focused on equity, and how the collaborative network promotes the development of strategic leadership skills and sharing of ideas, resources, and strategies.

A participant commented: "Great help from the leaders of the [Disparities Leadership Program] and…teammates by sharing ideas on coalition building, framing the message and the urgency and effective methods on educating leadership to get 'buy in' on the collection of race, ethnicity and language data. The exchange of ideas and the sharing of best practices with the group proved to be invaluable."

Discussion

These findings are the first to capture the perspectives of a large, diverse cohort of health plan, hospital, and health center leaders who have engaged in strategies to improve quality, address racial and ethnic disparities in health care, and achieve equity. A broad look at these results yields two important observations. First, health care leaders seem to possess knowledge about what disparities are and about what should be done to eliminate them. As is the case with other quality improvement efforts, data collection, performance measurement, and multifaceted interventions remain the tools of the trade, and the need to apply them to address disparities is clear. Second, the barriers to success are lack of leadership buy-in, organizational prioritization, energy, and execution—all which can be addressed through organizational change management strategies.

A systematic approach to organizational change management is beneficial when change requires that individuals throughout an organization learn new behaviors and skills. It is important to formally set expectations, employ tools to improve communication, and seek ways to reduce misinformation, so that stakeholders are more likely to buy into a change and remain committed to it. Getting past the discomfort associated with change will lead to a sustained innovation that provides better quality of service and improves an organization.[16,17] For each of the domains we identified in our participants' responses, we identified strategies that health care organizations will need to consider using when addressing disparities.

KNOW WHO TO INVOLVE One of the most common challenges reported by participants was related to leadership. This included lack of leadership buy-in; leadership turnover; and structural changes to the organization, such as mergers. Organizational change management describes the need for leadership buy-in, which includes both a well-aligned group of executives supported by the CEO and a powerful guiding coalition of internal stakeholders.[14,15] This applies directly to work focused on disparities. Strategies for securing leadership buy-in cited by our survey respondents included having executive or faculty champions and conducting presentations on disparities to executive leaders. However, executive leadership support alone will not guarantee successful organizational transformation. Efforts need to include midlevel and front-line staff members, who should be involved early in the process.[15] Participants highlighted developing internal collaborations across departments or projects; establishing a committed, diverse, high-functioning work group; and having a health equity office as important for successfully engaging midlevel and front-line staff. Being engaged in a national disparities program and having an alumni network to access for support, information, and collaboration also facilitated credibility and leadership buy-in.

SHAPE ORGANIZATIONAL CULTURE Institutional culture is critical to organizational change management, yet leaders often fail to take existing culture into account when designing transformation efforts, assuming that the culture will adapt with minimal effort.[15] Cultural barriers were frequently cited by participants. These barriers included difficulty integrating disparities reduction efforts into current work, a lack of alignment between disparities efforts and the organization's mission, lack of engagement, and lack of understanding or awareness of disparities. Sustaining innovation means anchoring change in the existing culture by looking for elements of the culture that are aligned with the change and bringing them into the foreground.[14,15] For example, respondents were generally very successful once they linked disparities to quality or integrated disparities work into other initiatives or priorities. Either disparities efforts should be anchored in the current cul-

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ture, or the current culture should evolve to include disparities work.

CREATE URGENCY AND A VISION AND MAKE THE RATIONAL AND EMOTIONAL CASE Transforming an organization first requires creating a sense of urgency that will drive change, and this is often created by leadership.[14–18] If leadership buy-in was lacking or there was turnover in leadership, respondents reported that urgency was lost and it became difficult to create an incentive for change. Participants noted that the ability to benchmark their organization's disparities data or interventions against those of other organizations within their collaborative network (both within their program cohort and in the alumni group as a whole) helped them increase the sense of urgency within their organization by creating a real-world standard demonstrating that other organizations were doing something similar or even more advanced.

Health care leaders also need to be able to easily communicate a vision that clarifies the direction the organization needs to take.[14] Respondents found it helpful to develop this vision as part of an exercise in the program focused on creating a "rocket pitch"—or a vehicle for describing a project, proposal, or idea in a clear concise manner.[19,20] Finally, for the vision to drive change, it needs to make the emotional and rational case for the change.[15] Respondents generally found that developing a communication strategy on disparities, combining disparities data with patient stories, focusing on branding and strategic marketing, and disseminating information about their progress locally and nationally were strategies that led to success in achieving the vision within their organization.

ENGAGE YOUR ORGANIZATION AND YOUR AUDIENCE Strategic leaders need to use communication, trust building, and frequent engagement to align themselves with key stakeholders who may not necessarily have the same view or agenda.[21] This lack of buy-in is especially common regarding strategies to address disparities, as there remains resistance to investing in these strategies. When our survey respondents faced challenges such as lack of engagement, coordination within the organization, or organizational buy-in, they shared their vision of how to address disparities early and often to engage key internal and external stakeholders. Respondents' successful strategies for communication included developing internal and external partnerships (including through networks), developing community partnerships, leveraging their participation in a national disparities collaborative, and developing synergies with other stakeholders by collaborating on other projects.

Organizational change management requires continuous engagement through constant communication, even after a project or strategic plan is implemented, and planning for and creating short-term wins to maintain the sense of urgency.[14,15] One example of how respondents achieved this was by leveraging awards or recognition they received to create awareness of disparities efforts within their organization. Other strategies for engagement included dissemination of information about their disparities efforts through presentations at local and national conferences on quality, diversity, and disparities; accessing tools, best practices, or case studies on disparities through the collaborative network; benchmarking disparities data or interventions with other organizations; and publishing their work in peer-reviewed journals. A final key to engagement is ensuring that senior leaders model new behavior or changes immediately by incorporating them into day-to-day business.[15] This highlights the need for executive and faculty champions who can, for example, request quality data stratified by race, ethnicity, and language for their department.

HARNESS THE POWER OF A COLLABORATIVE NETWORK Respondents cited the power of a collaborative network (within both their class cohort and the alumni network as a whole) in strengthening skills necessary for strategic leadership. For example, strategic leaders anticipate changes in their environment by constantly scanning for any signals of change and leveraging current drivers, state or national policies, or any relevant action external to the organization.[21] Access to a collaborative network improved leaders' abilities to anticipate the changing environment through benchmarking, exposure to other models, access to up-to-date evidence on disparities, and general networking and peer support.

Strategic leaders also promote a culture of learning that examines both successful and unsuccessful outcomes.[21] Through a collaborative network, respondents accessed best practices, common pitfalls, and strategies for addressing barriers and benchmarking organizational progress with others.

Lastly, strategic leaders challenge assumptions and encourage divergent points of view.[21] Through the collaborative network, respondents built a better foundation for challenging the status quo and current assumptions by sharing tools, case studies, and other resources.

Conclusion

Even with the lack of clarity surrounding the future of the ACA, the drive to high-value health care is well under way, and the United States is

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clearly on a path toward transformation of the health care system. We reviewed nine years of qualitative data collected from Disparities Leadership Program participants. Current efforts to address racial and ethnic disparities will require more than just the clinical interventions commonly discussed today (such as data collection, chronic disease management, and reducing readmissions). For organizations to be successful, health care leaders need to consider disparities efforts as a sustained innovation and strategy that can transform their organizations. Organizational change management strategies have not typically been applied in the context of disparities reduction. However, our research indicates that these strategies are necessary for health care organizations to be effective in making needed changes. The factors identified here as critical to success provide a blueprint for facilitating the organizational change necessary to address disparities and achieve equity. In addition, the benefits of participating in a disparities network or collaborative, such as the Disparities Leadership Program, should not be overlooked. To achieve the goal of value and high-quality care for all, organizational change management strategies will be essential. ■

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