

DLP CASE STUDY – Alameda Health Systems

Year Participated in DLP: 2010-2011

Background

The Alameda Health Systems (AHS) is a system of safety net hospitals and clinics for the largest county in the San Francisco Bay Area. Alameda County has the largest percentage of non-white residents in the Bay Area. English is the primary language spoken in only two-thirds of households in the county. AHS has a diverse client base and a diverse staff with a great deal of passion for working with the underserved.

Before participating in the DLP, AHS had a few champions for eliminating disparities and a robust interpreter services department with the capacity to serve over 28 different languages with both in person and video assisted interpretation. However, there was little infrastructure and few flexible resources to invest in system level interventions specifically targeted towards reducing health disparities. Existing performance dashboards for core measures were not stratified by measures such as race, ethnicity, or language. Champions within the Medical Staff were working in silos and in some situations having success, but their efforts were not well known.

Participation in the DLP

In 2007, AHS's Medical Staff President, Dr. Hunt, received a notification about the DLP and asked Dr. Swift if she thought any of the medical staff would want to participate in the program. Dr. Swift saw this as an opportunity for AHS to participate in a structured program with subject matter experts in the field. With strong support from the CEO, a team was sent to the DLP.

The continued coaching and mentoring from the DLP allowed AHS to focus on several different projects that started in very specific areas and eventually expanded to include a system wide approach. Over the past four years, AHS has had more teams participate in the DLP than any other institution. Participating in the DLP has enabled AHS to have access to technical resources and a network of others in the field that have been vital to their progress. They have used their three DLP projects to focus time and attention on efforts to collect, stratify, and use race, ethnicity, and language (REaL) data and to build an infrastructure that makes health equity a sustained organizational priority.

DLP Project Overviews and Outcomes

DLP Year 2008-2009

Overview:

The project goal was to address disparities in the heart failure population at AHS by aligning with existing activities designed to reduce readmissions. The project involved creating a disparities dashboard to assess and monitor access to evidenced based medication regimes.

Outcomes:

While AHS continues to work on reducing overall readmissions with heart failure, the team was able to create a disparities dashboard and determined that access to medications in the clinic was equitable when stratified by race. The team was also able to assess the strengths and weaknesses of existing data collection systems in the organizations, specifically in the areas of registration and core measures. Simultaneously AHS's CEO Wright Lassiter III, a strong supporter of the team, added the reduction of health disparities to the organization's vision statement.

DLP Year 2009-2010

Overview:

The stars were aligning at AHS with the promise of meaningful change, but funds were tight. Scholarships from the DLP allowed AHS to deploy a second team. The project goal was to complete a strategic plan for addressing inequities. Wright Lassiter III recruited Dr. Sang-ick Chang as the new CMO, a visionary physician leader with a passion for underserved populations and over two decades of experience in safety-net systems. Under Dr. Chang's leadership, the team initiated its first two system level interventions. The first was the creation of a new position in the organization: Medical Director of Health Equity and Patient Experience, which is currently held by Dr. Swift. The second was the creation of the AHS Equity Council. This council is co-chaired by Wright Lassiter III and Dan Bogan, the President of the Board of Trustees.

I think from a financial perspective there was no way anyone at AHS was going to approve more teams going to DLP because every year we are so cash poor. We have three or four weeks of cash on hand every given day. We have pockets of restricted funds that we can't touch. So the financial support was amazing. (Annette Johnson)

Outcomes:

In the first year, the Council identified the accurate and standardized collection of improving REal data as an institutional priority. The REal Data Collection Improvement Committee was created and tasked with incorporating best practices into existing data systems and the new electronic health record that AHS was planning to launch in the near future. Best practices were identified for race, ethnicity and language, and the registration staff received additional training to ensure accurate collection across all sites within AHS.

DLP Year 2011-2012

Overview:

In the third year, the AHS team committed to two additional projects in the areas of patient experience and overall system readiness for health equity. The team was keen to determine if there were differences in the way that various populations experienced care. The goal was to create a system-wide equity report for patient experience by improving the REaL data collected at the point of registration, regularly report on this data, stratify by a few measures of vulnerability, and create and disseminate a patient experience report for the seven service lines stratified by agreed-upon measures. The team also wanted to understand the “readiness” of the organization to address equity in the areas of cultural competence, governance, data collection, quality improvement, and community outreach.

Outcomes:

AHS stratified patient experience survey results by race and language. Dashboards now include core quality measures, which are shared quarterly at every Equity Council meeting. These dashboards are reviewed at System Operations Councils for each site. In addition, AHS surveyed physicians, managers, and C-Suite leaders to determine AHS’s current state of Health Equity Readiness. Results evaluated the organization, and strengths and weaknesses were identified in each of the five areas surveyed. The results of this survey were used to set the Equity Council’s 2012-2013 goals and priorities.

Key Success Factors

Connection to DSC and participation in DLP

AHS has participated three times in the DLP and used each round of participation to advance the scope and quality of its disparities work. DSC staff have been strongly supportive and encouraging of AHS’s disparities work and celebrated their accomplishments. Support has been provided in the form of phone conferences and site visits.

Health equity champions

The DLP has contributed to identification and growth of health equity champions with AHS. AHS employees who have participated in the DLP program share a common language and purpose and spread this knowledge and vision to others in the organization through equity projects and work teams. In addition, access to a network of DLP alumni and health equity peers has been a tremendous resource for advancing equity within AHS.

Executive leadership support

The top leadership at AHS has been fully engaged and supportive of reducing health inequities. They formed a Health Equity Council with leadership at the highest level of the organization. The Board integrated health equity into the strategic plan.

Our CEO and President of the Board are deeply committed to eliminating health disparities. They always encourage us to be bold and think broadly. (Dr. Mini Swift)

Grant to build infrastructure

AHS received a CMS Grant that provides \$27 million a year to build infrastructure to expand primary care and specialty access, inpatient service, population management, and harm reduction strategies. Dashboards for population management will be stratified by race, ethnicity, and language when appropriate.

Expanded quality leadership distributed across the organization

The quality department has embraced health equity and has emerged as the primary driver in the organization for health equity. The number of analysts has been expanded. The goal is to have a quality analyst be part of every health equity project team so that quality improvement and health equity efforts can be further integrated.

Being cited by Centers for Medicare and Medicaid Services (CMS)

Recent surveys by CMS (Centers for Medicare and Medicaid Services) and ACGME (Accreditation Council for Graduate Medical education) have highlighted opportunities in the use of interpreter services. Increasing the availability of equipment, making it easier to use, and providing guidance on when and how to contact interpreter services has allowed AHS to capitalize on its robust interpreter programs to improve patient safety and patient and staff experience of care.

Having executive leadership on the Health Equity Council

The CEO and the Board sit on the Health Equity Council. The Council meets quarterly, looks at disparities data, and coordinates quality and health equity work across the organization.

Having the upper management on board really helps push what is plausible forward. This helps get things going. We've been asking people to come and present their projects to the CEO. When people hear directly from the boss how important this work is, it helps to clarify how to align equity with strategic goals. (Ms. Johnson)

The Equity Council helps us build accountability and to weave together multiple strategic initiatives through the lens of health equity. (Dr. Swift)

The Affordable Care Act

The health equity champions within the organization were able to use the requirements in the Affordable Care Act to set data collection priorities to be included in the design of the electronic health records.

Challenges to Making Progress

Time it takes to show results

I think the problem with change management when you are dealing with disparities is that the pain isn't immediately visible like it is when you don't have funds to deliver patient care. It makes it harder to drive the change. And the steps don't always lead to immediate results. (Dr. Swift)

Integrating multiple health equity projects

Prior to the Health Equity Council, champions across the organization were independently working on equity projects and were not necessarily aware of each other's efforts. The Quality Department, under direction from Health Equity Council, is working to align and coordinate these projects to ensure system-wide quality and equity.

Lack of utilization of interpreter services

In a needs assessment of physicians, AHS learned that many of the staff do not understand the variety of modalities that are available and how to access them. Others have preferences for one type of service over another even when those services are not widely available because of their high cost. A next step for AHS is to "create standards around using each modality, making sure everyone understands the different ones, and then to step back and assess the need."

Ripple Effects

Emerging leadership

Since there were multiple competing priorities at AHS, the council decided to take an "equity in operations" approach so that leaders could look for opportunities to incorporate principles of health equity within existing projects and initiatives. As a result there is a broader conversation about equity within the organization. AHS is just beginning to see the concepts of equity spread into new areas. The communications director, for instance, pushed the organization's leadership to approve a report to the community that included a breakdown of patients and staff by race.

Becoming public champions

The CEO used his platform as President of the Board of the California Association of Public Hospitals to talk with all the CEOs of the California Safety Net about what AHS was doing to advance equity.

Partnership

AHS is discussing a partnership with Kaiser to assess and train AHS's bilingual staff to provide backup language services appropriate to their fluency.

DLP and Peer Support

DLP Support

The DLP has been an ocean of support. While AHS's equity work has always had the full support of the executive team, we always need to find ways to support our middle management,

as they have so much on their plate. The coaching from the DLP has been priceless in helping to spread a unified vision and mission across the organization. The tolerance for my changing the scope of my project halfway through, letting us do our own thing, and offering for us to reach out anytime was invaluable. (Dr. Swift)

I think the structure of the DLP helped us make disparities a priority, and that made a huge difference in the quality of our data. (Benita McLarin)

The DLP emphasized the importance of linking this work into the quality department and to get some early wins like the core measures. (Dr. Swift)

We used MGH's Blueprint to report to the Health Equity Council. It also helped us decide to use a two question format to collect race and ethnicity data. (Dr. Swift)

Joe [Betancourt] came out in 2010 and kicked off our Health Equity Council. Joe has spent a lot of time investing in our work. Our CEO really values this partnership. (Dr. Swift)

We reached out to the DLP to get background info for language services. Aswita [Tan-Mcgrory] provided examples of interpreter etiquette guidelines, which we used to build our own. (Ms. Johnson)

Aswita reached out to DLP alumni for samples when we were creating the job description for Medical Director/ Director of Equity. (Dr. Swift)

Peer support

A DLP colleague created a 1,500 page manual called, "We Ask Because We Care" from Minnesota. AHS adapted their education and survey pieces to AHS. This was fundamental to how we got moving on the REaL Project, e.g., leveraging each other's work and adapting as you go. (Ms. Johnson)

Initiatives on the Horizon

Expanding participation in DLP

My dream is to send champions for all major strategic initiatives to the DLP so that they can incorporate equity into any improvement project at AHS. (Dr. Swift)

Integrating equity and operations

Taking an "equity in operations" approach will be so much more useful given that there are so many improvement projects going on across the board. We are trying to make this part of the culture. We are trying to make this part of everything so it will stick around. (Annette Johnson)

Gender identification

We are struggling with the gender issues. There is new law to allow gender identification. The question is do we need to capture biological sex – several health screenings are tied to gender. How do we provide culturally sensitive care? This is the next step for REaL. (Ms. Johnson)

Set up and test a system to do crosswalks across the data

We are going to try and roll out the same model for our physicians and employed staff so that we can cross-compare to have a robust picture to stratify our data. (Dr. Swift)

Case Study Informants

DLP Leads

Dr. Mini Swift, Medical Director of Patient Experience & Utilization Review
Annette Johnson, Quality Services Division Quality Analyst
Benita McLarin, VP of Ambulatory Division

Other Informants

Max Schumm, Quality and Improvement Intern
Sambo Ly, Director of Language Services
Phillip Morris, Clinical Manager of K-6
Julie Halsey, Organizational Learning and Effectiveness, Human Resources
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