POSTER ABSTRACT

The ‘waze’ of inequity reduction frameworks for organizations

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Introduction: Analogous to the Waze driving navigation software, different conceptual frameworks offer guidance for how an organization can change its policies and practices to make care and outcomes more equitable for patients, and how the organization itself can become more equitable. Nonetheless, health care organizations often struggle with implementing these frameworks that require simultaneously addressing the needs of both patients and employees. Using organizational change theory, we assessed what guidance frameworks provide, and what are the existing caveats that hinder successful implementation to make care and outcomes more equitable.

Methods: Fourteen inequity frameworks from scoping literature review 2000-2017 that provided models for improving disparities in quality of care or outcomes were assessed. We analyzed how frameworks addressed key implementation factors: (1) outer and inner organizational contexts; (2) process of translating and implementing equity interventions throughout organizations, (3) organizational and patient outcomes, and (4) sustainability of change over time. Following our assessment, we conducted member check interviews with framework authors to verify our assessments.

Results: Frameworks stressed assessing the organization’s outer context, such as population served, for tailoring change strategies. Inner context, such as existing organizational culture or readiness for change, was often not addressed. Most frameworks did not provide guidance on translation of equity across multiple organizational departments and levels. Recommended evaluation metrics focused mainly on patient outcomes, leaving organizational measures unassessed. Sustainability was not addressed by most frameworks. Interviews conducted with 10 framework authors verified our assessment overall and did not raise any major discrepancies.

Discussion: Existing models focus on assessing the outer organizational context mainly through analyzing racial and ethnic data and interacting with community representatives. They recommend implementing macro-level change processes such as cultural competence training of staff, increasing workforce diversity and assessing patient outcomes. Yet they often overlook inner organizational context such as readiness for change. Additionally, the process of intra-organizational translation, adaptation, and implementation across different department and staff levels remain a black box for organizations to decipher. Middle managers entrusted with driving change and implementation often lack the knowledge and skills to effectively translate change processes.
Conclusions: Existing inequity reduction frameworks and models lack important guidance to organizations for the practical implementation of change efforts, tending to focus on broad 30,000 feet statements.

Lessons Learned: Management personnel should receive training in ‘Translational Management’, where they learn how to contextualize and implement equity in their specific departments. Additionally, guidelines and strategies focusing on institutionalization and sustainability are crucial, considering competing organizational interests and changing environments.

Limitations: We did not include every patient term for social risk and thus some equity frameworks may have been excluded. Yet, it is unlikely that the overall findings would be significantly different as models from multiple health care systems, countries, and contexts were reviewed. Additionally, we may have misinterpreted or misclassified the frameworks. However, we were able to confirm the interpretations with authors of most of the models.

Suggestions for Future Research: Comparative case studies evaluating organizational-wide inequity reduction efforts will assist in enhancing existing frameworks to address identified caveats.

Keywords: inequities; disparities; organizational change; frameworks; implementation