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Leadership strategies to improve healthcare outcomes

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VITA

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ABSTRACT

The disparities in healthcare and the challenges of healthcare leaders in achieving positive health outcomes are a priority in America. Much discourse and policy is currently evolving in the legislative and executive branches of government. The United States has the highest health expenditures in the world and is classified as one of the unhealthiest countries. Many factors contribute to the disparities. These factors include socioeconomic, cultural competency, social determinants, policy, and health leadership. The challenge for health leaders is to identify strategies to improve the trends and e the status of health quality and well-being for all Americans. This study employed qualitative research using a phenomenological approach; surveying healthcare leaders in the United States. Data collection employed in-depth interviews of healthcare leaders with at least two years of experience in their current role. This qualitative study identified challenges of leaders in health care, best practices of successful healthcare leaders to improve patient access, narrow the gap of health-related disparities, and evaluated techniques and methods to improve health outcomes across racial and ethnic groups.

The research questions (RQ) posed in the research were:

RQ1: What are the challenges you face regarding influencing healthcare outcomes?

RQ2: What current strategies do you use to address these challenges and barriers?

RQ3: How do you measure and track your success with overcoming challenges and barriers?

RQ4:What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?

Chapter 1: Study Overview

Introduction

Disparities in the American healthcare system are broad and can result from a myriad of access, leadership, and systemic issues (Copeland, 2005). Challenges in the arena of healthcare disparities span across race, ethnicity, geography, economics, policy, and delivery. Minority populations face disparities in healthcare in areas of treatment, outcomes, and access. These factors are well documented, and data indicate that members of diverse groups are disproportionately impacted (Copeland, 2005). Due to the depth of dimensions in healthcare, the challenge is for policymakers and health leaders to accurately define the challenges for the creation and implementation of solutions. With respect to the U.S., researchers revealed that Americans receive 55% of the medical care suggested for major illnesses (Frist, 2005). When outcomes were studied for these illnesses with respect to race, socioeconomic status, geography, and ethnicity, the issues in quality were dismal (Frist, 2005). Healthcare delivery continues to be a priority in the public, private, and political sectors of society.

The burden of cost, affordability of health insurance, improving healthcare outcomes, and access to care impact the nation on a state and local level. The World Health Organization defined health as an overall state of well-being to include physical, mental, and social wellness, in addition to the absence of infirmity (Koh, 2016). Unfortunately, for most Americans, this state of wellness is not achievable. The U.S. outspends other nations on health, but statistics indicate Americans are the unhealthiest. Americans rank 43rd worldwide in life expectancy with variation between the top and bottom 1% in income distribution (Koh, 2016). In addition, disparities exist by gender, race, ethnicity, and geography. With respect to race, minorities represent a third of the U.S. population. These groups face health disparities in outcomes, access to care, and how

healthcare is delivered. Contributory factors are well documented, and data indicate that members of diverse groups are disproportionately impacted. African American and Hispanics are the overrepresented groups of the uninsured, comprising 13% of the U.S. population, and a quarter of uninsured Americans (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Inequities in care for those minorities with access to the healthcare system are also a concern. Lack of insurance has a significant and detrimental impact on this population, resulting in reduced availability to preventive care than the insured, increased incidents of emergency department use, unnecessary hospitalizations, end-stage cancer diagnosis, and lack of means and access for medications (Betancourt et al., 2003).

The U.S. government plays a role in addressing issues on healthcare and disparities. The government provides leadership, policy, and sets the tone by increasing the dialogue and urgency with initiatives and laws to reduce health disparities (Andrulis, 2003). Commonly, the discourse on health affordability and access becomes the focal point of politics and a dividing line between political parties with respect to policy. Discourse on the cost of healthcare and healthcare reform spurred the development of the Patient Protection and Affordable Care Act (ACA) created to provide access to more citizens at an affordable rate. Since the ACA became law in 2010, more than eight million citizens enrolled, with women and minorities among the new subscribers, thus mitigating the barrier of access for many. By most standards, the ACA is successful; the number of uninsured Americans is at its lowest level in half a decade and the ability to obtain health care improved for millions of Americans (Jost, 2015). In addition, the costly burden of hospitals caring for the uninsured has declined in response to the expansion of Medicaid (Jost, 2015).

The objective of this research was to examine the existing state of healthcare and healthcare policy to determine its impact on supporting the healthcare needs of many with

respect to cost, access, affordability, and outcomes. The current system and market favors those who have financial means to pay for better coverage while the staggering costs for middle and working classes and small business owners represent limited resources and options for healthcare. The monumental challenge for the U.S. in improving the current system of health coverage for its citizens is gaining consensus of the goal among policy makers. Distinctions in governance and creation of health policy involve the positions of healthcare as a right or privilege. As healthcare professionals, medical leaders, and policy makers differ on whether health care is a basic civil right, or a privilege afforded to the wealthy, the laws created to benefit the underserved segments of society are imperative to support access and affordability for every member (Bauchner, 2017).

This study sought to add to the body of knowledge concerning healthcare outcomes, access to care, and potential financial burdens for these treatment groups. These questions may also lead to a better understanding of the policy making process that governs access to healthcare from the perspectives of medical leadership and policy makers. Using both phenomenological and qualitative approaches, this research evaluated the issues confronting healthcare leaders in management, treatment of chronic diseases that increase morbidity, compared demographic trends, and evaluated future costs. The objective was to evaluate the impact of healthcare disparities across populations and society and provide insight on models to impact change. This study employed a qualitative methodology. The qualitative approach analyzed data obtained from healthcare leaders in patient facing roles, executive administrators, managed care leaders, and hospital executives.

The theoretical framework for this research aligns with principles of leadership ethics. Ethics are the values and morals of a society that are deemed suited and appropriate (Ciulla,

2004). There is also an assumption that society is responsible for the needs and care of its population. There is a belief that action to further the greater good supersedes financial gain. The utilitarian teleological approach advocates that behaviors should be created to provide the best for the all (Schumann, 2001). With this view, a morally correct position adds value to social benefits while decreasing the social costs (Schumann, 2001). Therefore, if governments allocate appropriate budget and access to healthcare for all, preventative measures can be implemented to curtail catastrophic diseases and morbidity. This utilitarian perspective would apply policy and use resources for the best outcome for the greater population and medical leaders. The theoretical framework of transformational leadership frames how leaders engage with their group and create a connection resulting in increased levels of motivation and morality (Bass & Steidlmeier, 1999). The avoidance of the health disparities, attributed to the lack of concern and attention by non-diverse health leadership, may be overhauled by an approach consistent with this leadership model. Transformational leadership must be consistently demonstrated and built into the fabric of the company. The culture and values must be established to support the ideals and visions of the firm and most importantly to impact and benefit others and not on self-seeking interests.

Avolio and Bass (1995) identified four factors in their leadership model to frame transformational leadership—influence and charisma, motivation, intelligence, and individual consideration—that can result in exceeding performance. The first step is to recognize the strong leaders in place who have the charisma and ability to influence. The influence must be based on a place of trust and integrity. The leaders must articulate the vision devised from the needs of the organization and the followers must align and believe it. Even in an environment with a degree of uncertainty in the vision, followers are likely to follow the mission and vision set forth by these leaders. The next step is for leaders to be specific in providing the expectations and

sharing, through inspiration, how the follower's role in the plan contributes to the overall objective and future of the company (Avolio & Bass, 1995). The skill to motivate, inspire, and include motivation of the followers in a shared vision will foster inclusion and innovation (Avolio & Bass, 1995). This model, if embraced by health care leadership, could evolve new practices, policy, and goals to set the course for change in the industry (Avolio & Bass, 1995). The factors that distinguish transformational leaders are:

- Idealized influence: Leaders who are strong role models for followers and cause their followers to identify with them.
- Inspirational motivation: Leaders embrace lofty standards and expectations for their followers and inspire motivation toward the shared vision.
- Individualized consideration: The supporters that create an environment to address individual needs of its members.
- Intellectual stimulation (Avolio & Bass, 1995).

Healthcare Delivery

Healthcare organizations are challenged to have dynamic leaders across all facets of the expansive $1.7 trillion healthcare industry (Dzau, 2017). According to Scheck (2006), despite the growth of interest for developing healthcare leaders, little is known about their training and development. Additional issues where leaders have a responsibility are concern for healthcare access and allocation of services. The procedures and structure of health systems impact how accessible services are for patients (Nelson et al., 2003). Because of the complicated matrices upon which health systems are structured and financed, factors such as reimbursement and payment procedures, as well as geographic and linguistic barriers, may directly impact racial and ethnic minorities (Nelson et al., 2003). With pervasive challenges and worsening health

disparities, the health care costs remain excessive (Dzau, 2017). The annual health care estimates for the U.S. are $3.2 trillion, whereby 30% of the costs are attributed to waste, ineffective policy, and exorbitant costs (Dzau, 2017).

Leaders of health organizations are in demand to practice with competency and generate acceptable patient outcomes (Saeed, Bloch, & Silver, 2015). Although care teams are tasked as a group to deliver patient care, it is usually the responsibility of the physician to make changes to impact clinical outcomes (Saeed et al., 2015). To achieve outcomes based on best methods proven to deliver advantages for a patient's recovery and remission, medical providers must stay up to date with information. The application of evidence-based treatment and evaluation of the plethora of clinical research must be a priority for the clinical and healthcare leaders (Saeed et al., 2015). In addition, many clinicians work for healthcare organizations and these organizations can intentionally or unintentionally influence physician behaviors and employ educational interventions. With the pace of technological advances, the information flow and knowledge often outpace traditional treatment guidelines and protocols (Saeed et al., 2015).

Additional challenges in information flow include the rapid pace of its advancement. Physician practice is aligned to medical practice guidelines, and medical knowledge grows at an exponential rate. The growth in clinical research has relevance for clinicians in knowing which medical protocol or treatment guideline to adhere to improve patient outcomes; the information the physician acquires at the time of graduation will be obsolete 10 years later. Physicians spend 25% of their time learning and managing updates in medical information and that the volume of data is doubling every five years (Saeed et al., 2015).

The challenge of information overload is that leaders often cannot dictate how clinicians use the information for patients. Another challenge is the limited time physicians have in which

to tailor the information to the individual needs of patients, patient's lack of response to treatment, or the authority of leaders which may induce negative working conditions for providers. In addition, evidence indicates a physician's stress level and time pressures have a correlation to physician errors, misguided patient care, and prescribing errors (Ryn et al., 2011).

Cognitive Load

Another factor impacting health delivery is the personal strain of healthcare providers. Cognitive overload of providers may play a role in causing medical stereotyping instead of individualized treatment. Burgess (2010) found that healthcare disparities may be a result of the clinician's diagnostic and therapeutic decision-making ability and that the result may be a function of cognitive overload (Burgess, 2010). Cognitive overload is the level of mental activity on a working memory that is competing with other areas (Burgess, 2010). Examples of competing areas are psychological and physiological states, mental tasks, environmental factors, and task attention (Burgess, 2010). The concept addresses the quantity of overload rather than the state of overload. The concept of cognitive overload is based on social cognition where the automatic and controlled processes of the brain filter mental activity (Burgess, 2010). For example, the controlled mechanism addresses intentional, conscious, and effortful thought. The problem occurs when there are excessive levels of cognitive load and the controlled process can be impaired or interrupted by assuming more cognitive resources (Burgess, 2010).

In a medical setting, providers who demonstrate elevated levels of cognitive load may contribute to impacting racial disparities (Burgess, 2010). Due to lower use of controlled processing, individuals make poor decisions from their increased reliance on interpersonal behaviors influenced by personal stereotypes (Burgess, 2010). Racial bias and preconceived bias are likely to affect cognition and behavior when cognitive capacity is overtaxed (Ryn et al.,

2011). This stereotyping leads to poorer health care outcomes and healthcare processes for minority patients. The harmful effects of the cognitive overload are attributed to stress, mental distress, exhaustion, time pressure on medical errors, and workload (Burgess, 2010).

Burgess (2010) found that the autonomic processes can unconsciously or consciously apply stereotyping referred to as implicit stereotyping. Based on research, evidence has demonstrated that Caucasian physicians have implicit beliefs about African American patients, which affect biases in their medical decision making (Burgess, 2010). However, autonomic processes can be improved with adequate amount of cognitive resources and motivation from the medical provider. Recommendations to reduce the cognitive load include establishing routines, adequate staffing, allowing more time between patients, reducing noise levels, and improved training. Sufficient cognitive resources allow individuation, focus on unique characteristics of the patient, respectful interaction, and correction of judgment (Ryn et al., 2011).

Barriers to Access

The burden of cost, concern with healthcare outcomes, and access to care impact the nation and pose a moral and ethical crisis thwarting efforts to improve health outcomes (Copeland, 2005). Disparities from treatment to outcomes represent a major challenge in the American healthcare system (Betancourt, Corbett, & Bondaryk, 2014). Discourse on the cost of healthcare has formed recent policy—like the ACA—designed to provide access to more citizens at an affordable rate. Since the ACA became law, more than 8 million Americans have enrolled in the health exchange, with women and minorities well represented among the new subscribers (Adepoju, Preston, & Gonzales, 2015). The ACA has provided increased healthcare access for many, thus mitigating the clinical barriers of access to many former uninsured (Jost, 2015). Although the ACA has opened doors to access, African Americans and Hispanics are the groups

most overrepresented among the 32 million remaining uninsured, representing 13% of the U.S. population (Betancourt et al., 2003). The disparities in quality of care for minorities who have access to healthcare are also of concern to healthcare leaders. The medical areas where procedures and diagnostic tests are underutilized for racial and ethnic groups compared to the Caucasian population are preventive, therapeutic, and diagnostic areas of treatment (Washington et al., 2007). Examples are in the use of cancer surgeries, kidney transplants, treatment for pneumonia, congestive heart failure, and Medicare coverage for specific services (Betancourt, et al., 2003).

Another group confronted with barriers to care are those individuals that may be employed, but qualify for Medicaid due to the expansion of Medicaid in the ACA. The expansion provides insurance benefits for those who fall within the guidelines of providing Medicaid to individuals who are classified up to 138% of the poverty level. The ACA also subsidizes coverage for those who fall within the subsidized marketplace coverage within 100% to 400% of the poverty threshold who may not be eligible or qualify for employer benefits (Adbus, Mistry, & Selden, 2015). This group can be defined as the beneficiaries of Medicaid expansion associated with the ACA (Kimbrough-Melton, 2013). The states that opted to decrease the income level for enrollment benefitted the working class that lacked the disposable income to purchase health insurance (Connors & Gostin, 2010). Recent healthcare reform's extension of coverage to many has benefited the uninsured. Unfortunately, insurance alone cannot solve health disparities or improve the American health status. More effort must to be on improving overall health and health outcomes (Awosogba et al., 2013).

Social Determinants

In the U.S., individuals are exposed to many cultural, economic, social, educational, and geographic factors that impact their health and health outcomes (Awosogba et al., 2013). Health literacy, cultural competency, rural medicine, and diversity education in academic settings are additional interconnected social determinants that can provide solutions to improved health (Awosogba et al., 2013). For example, individuals with less than a high school diploma will report bad health four times more often than those with a college education (Awosogba et al., 2013). Socioeconomic position defined by income or education also measures the quality of healthcare (Fiscella, Franks, Gold, & Clancy, 2000).

When evaluating the correlation of socioeconomics and race, the quality and discrepancies in health outcomes appear to be related to class levels. The variances in class levels are associated with fewer diagnostic tests, immunizations, prenatal care, lower quality of ambulatory and hospital care, fewer visits with specialists, and less intensive cancer treatment (Fiscella et al., 2000). In addition, the prevalence and outcomes from cardiovascular disease, diabetes, asthma, and cancer disproportionately affect minority groups.

According to Wong (2015), there are two factors that contribute to inequities. One hypothesis is based on insufficient data in clinical trials to represent the linkage to patient demographics, and a second hypothesis attributes correlation in disparities on the integrated demographic variables of race, access to insurance, economics, and societal issues (Wong, 2015). The Institute of Medicine research reports patients from traditional minority populations often report a lower quality of healthcare (Bowen, 2014). Even when adjusted for indicators of financial means—insured versus uninsured, age, and disease state—there are vast discrepancies

in the type and quality of medical care between Caucasians and African Americans (Cohen, Gabriel, & Terrell, 2002).

Health Outcomes

The etiologies of the challenges of healthcare providers are numerous. Commonly, this discourse becomes the focal point of politics and a dividing line between political parties. The U.S. outspends all nations in healthcare delivery, but has the lowest rates of favorable health outcomes (Connors & Gostin, 2010). The treatment outcomes do not come close to matching levels expected for those expenditures. There are data to support the idea that disparate results in care are a result of the inequities of the healthcare system (Wong, 2015). Underserved patient populations receive care in places that are broadly different in quality and disease management. Data on morbidity and mortality comparing patients across socioeconomic strata indicate socioeconomics contribute to mortality rates (Wong, 2015). Wealthier patients have lower morbidity rates than the poor. In addition, providers should consider patient beliefs, cultural values, and preferences to enhance patient-provider communication to build trust and comprehension (Wong, 2015).

Statement of the Problem

The healthcare setting is dynamic, encompassing systems of operation for healthcare institutions, medical practice groups, and healthcare coverage organizations (Nelson et al., 2003). Each entity has individual standard operating procedures, internal policies, and priorities not entirely aligned on the needs of the patients they serve (Betancourt et al., 2003). It is posited that healthcare is a costly and inefficient infrastructure that drains families and communities (Dzau, 2017). Health policy, services, access, patient care, and affordability are among the challenges confronting organizations and leaders (Nelson et al., 2003). The trillion-dollar healthcare

industry experiencing dynamic change and growth has bred a new line of leaders (Dzau, 2017). According to Scheck (2006), trends in most industries prioritize leadership development. Healthcare is one industry where little is known about how prepared leaders are in their awareness or competencies in solving the priorities in care. Thus, health care delivery, health disparities, barriers in access, health care outcomes, and the role of leaders all contribute to today's healthcare challenges impacting patients, medical providers, and healthcare leaders. Furthermore, the disparities in health are increasing, and the financial strain of major illnesses are creating an undue burden to families and their communities. Other factors impacting health delivery is the personal strain of healthcare providers. Advances in technology, volume of patients, reduction in reimbursement and cultural competency may factor into why disparities exist (Shirom & Nirel, 2006). These factors have contributed to transformational changes in how medicine is practiced and how healthcare is delivered (Shirom & Nirel, 2006). Changes in evidence-based medicine, patient-centered care, and case management require increased demand from providers and may contribute to the prevalence of physician burnout (Shirom & Nirel, 2006). The changes can also play a positive role, as technology and science breakthroughs have improved detection, prevention, and treatment of disease (Dzau, 2017). The challenge for medical practitioners is to identify the priorities and process that will have the most beneficial impact for the health of American citizens (Dzau, 2017).

Purpose Statement

This qualitative research identified leadership challenges in healthcare, strategies and practices of successful healthcare leaders to improve patient access, narrow the gap of health-related disparities, and evaluate techniques and methods to improve health outcomes across racial and ethnic groups. Moreover, this qualitative study intended to discover how the role of a

healthcare leader could effect change in policy and medical management to meet the challenges identified. The exploration of the leadership challenges in healthcare identified some of the current challenges faced by healthcare leaders in addressing issues in treatment, policy, and outcomes. The research questions also explored current strategies and practices employed by leaders to influence outcomes. Lastly, successful outcomes, their measurements, and how they are tracked were defined.

Research Questions

The research questions (RQ) posed in the research were:

RQ1: What are the challenges you face regarding influencing healthcare outcomes?

RQ2: What current strategies do you use to address these challenges and barriers?

RQ3: How do you measure and track your success with overcoming challenges and barriers?

RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?

Assumptions of the Study

The key assumption for this study identified the specific needs that must be addressed to improve the health disparities across ethnic and racial groups. Another assumption was that barriers exist in access to care for racial and ethnic minorities that impact prevention, treatment, and health outcomes. Lastly, healthcare leaders and providers were engaged to address the current challenges in healthcare and had a role in utilizing this research to lead to change and policy.

Limitations

Limitations of the qualitative design may have been reflected in the scope of the sample size, length of time of the study, and access to specific patient information. The breadth of respondent differentiation may have been impacted by geography. Interviews across states and regions may have produced differentiation in data. Additionally, due to HIPPA privacy laws, patient records on disease and healthcare limited access to data. Furthermore, ethnicity data and demographic data were vitally important in predicting the burden of disease and economic indicators, and for allocation of resources. Lastly, unlike qualitative research, the use of quantitative data may offer robust data in disease outcomes and fiscal impact.

Significance of the Study

According to Sullivan (2004), disparities in healthcare pose ethical and moral challenges that are a significant dilemma in the current healthcare system. In an industry known for continuous change, there is a need for strong executive leadership. This study has significance as challenges faced by healthcare leaders have implications for patients, healthcare providers, policymakers, and the U.S. economy. This research study might provide strategies for healthcare leaders to address many issues that influence healthcare outcomes. Additionally, from a leadership perspective, Saeed (2015) identified themes for challenges of healthcare leadership: lack of access cultural competence, leadership development, care coordination, and treatment to improve health outcomes.

Definition of Terms

Clinical barriers. Clinical barriers are roadblocks or gaps in the interaction with the healthcare clinician and the family or patient who reduces access to medical care (Betancourt et al., 2003).

Cognitive overload. Cognitive overload is the level of mental activity on a working memory that is competing with other areas (Burgess, 2010).

Cultural competence. Cultural competence is the awareness and inclusion of social cultural influences on patients' lifestyles and cultural beliefs (Betancourt et al., 2003).

Disparities. Disparities are factors that impact the quality of healthcare from racial, ethnic, or gender perceptions that are not caused by differences in medical need, patient preferences, or standards of medical intervention (Awosogba et al., 2013; Washington et al., 2007).

Leaders. Leaders are those who carry the duty and authority for the goals and policy of the organization (Oliver, 2006).

Medical leadership. Medical leadership is defined as medical providers, managers of health resources, gatekeepers, physicians and health leaders that influence processes of change, lead improvement, and have the have authority to impact clinical decision making (Frank, 2007).

Social cognition. Social cognition is the controlled and autonomic processes that address the distinct types of mental activities (Burgess, 2010).

Summary

In summary, the scope for addressing the present and future issues in improving healthcare outcomes and leadership strategies and the demands of the healthcare setting in contributing to biases in medical decision making will be incumbent on determining the specific causes of disparity, access, cognitive load, and financial determinants (Awosogba et al., 2013). From policy reform to access to quality care, disease outcomes must be addressed from an ethical and cost burden approach (Copeland, 2005). The influencers of policy, medical leadership, budget decision makers must be inclusive at all levels of the healthcare process (Jost,

2015). Attention to diversity in leadership can positively impact patients at a clinical level and potentially at a societal level. Furthermore, research in healthcare outcomes conclude that causes of disparities in health outcomes are attributed to the inequalities in the structure of the health system (Wong, 2015). With attention on resourcing, patient provider commitment to information, trust and understanding, early intervention, the gaps in the quality, and health outcomes may contribute to the leadership challenges and narrowing of gaps in disparities.

The issue of health disparities has significant consequences in minority populations. Much of the discussion is on access to healthcare, quality versus inequality, morbidity and mortality for minorities. The reform of health care has narrowed the gap for the uninsured and allowed millions of patients to secure health insurance. Challenges with disease burden, social determinants, health literacy, cultural competence, and healthcare delivery will remain as challenges to healthcare leaders to eliminate disparities. Public health programs, new processes in health care delivery, and health policy are considerations for leaders to employ to address these challenges in health disparities.

Chapter 2: Literature Review

Introduction

Disparities in the healthcare continuum from treatment to outcome continue to present a challenge in the healthcare system. As communities are becoming increasingly more diverse, patient-centric roles of healthcare providers, policy makers, and leaders are not reflecting their diverse constituents. The U.S. Census Bureau data reports that minorities make up one-third of the population; by 2043, they will be the majority (Bowen, 2014). The changes in the demographics over the next ten years validate the significance of addressing the ethnic and racial inequalities in health care (Betancourt et al., 2003). The World Health Organization defined health as an overall state of well-being to include physical, mental, and social wellness, in addition to the absence of infirmity (Koh, 2016). Health is also defined as being fundamental to the dignity and well-being of people and a mechanism for improving the quality of life (Kimbrough-Melton, 2013). Unfortunately, for most Americans, this state of wellness is not achievable.

The U.S. outspends other nations on health but research by Koh (2016) indicated the U.S. population is the unhealthiest. The U.S. ranks 43rd worldwide in life expectancy, with variation between the top and bottom 1% in income distribution (Koh, 2016). In addition, disparities exist by gender, race, ethnicity and geography. These groups face disparities in the delivery of care, outcomes, and access. Disparities in healthcare span across language, religious, cultural, gender, race, and ethnic distinctions. When these differences are not acknowledged and appreciated, their impact on the treatment and delivery of healthcare, healing, and trust lead to disparities in care. Without competent leadership in diversity, even culturally competent leaders in healthcare will not realize their capabilities (Dreachslin & Hobby, 2008). These factors are well documented,

and research by Betancourt et al. (2003), indicate that members of diverse groups are disproportionately impacted. African American and Hispanics are the overrepresented groups of the uninsured, representing 13% of the American population and 25% of uninsured Americans (Betancourt et al., 2003). Racial and ethnic disparities are concerning for those who may lack quality of care and access to healthcare. Lack of insurance has a significant and detrimental impact on this population, resulting in fewer preventive care measures, emergency utilization, avoidable hospitalizations, cancer 4 and 5 staging, and the access to prescription medications (Betancourt et al., 2003). This chapter discusses three foci of health outcomes: social determinants, healthcare leadership challenges, and healthcare strategies.

Social Determinants

The diverse groups who report bad health are growing in proportion to the U.S. population (Betancourt et al., 2003). Much of the research studied on the quality of health for diverse populations focuses on social determinants. Socio economics, social equity, and geography may influence the delivery and access to care. According the Institute of Medicine research, minority and ethnically diverse patients frequently receive a lower quality of healthcare that may not be attributed to a single factor (Bowen, 2014). Developing effective strategies to impact social determinants and achieve affordable and quality healthcare to a diverse patient population is a test for U.S. healthcare leaders to confront cultural and language barriers that have impacted health inequality (Dotson & Nuru-Jeter, 2012).

Socioeconomics

Socioeconomics and race are intertwined when looking at access and quality of healthcare received. It has long been agreed that major discrepancies in health outcomes are related to class levels. In interpreting household income, Williams (2015) stated that “in 2013,

each dollar of household income Caucasians earned, Hispanic households earned 70 cents and African Americans earned 59 cents" (p. 555). According to Williams (2015), socioeconomic status is a major determinant in the U.S. for health disparities when evaluated financial, educational, or occupational status. Disparities in health are also expensive for the U.S. in terms of morbidity in the productive years of life. The variance in mortality for African Americans and Caucasians is estimated to result in the early death of 260 African Americans daily (Williams, 2015). Finances are a major impediment to seeking healthcare for poor persons (Andrulis, 1998). The disproportionate access to healthcare and its contribution to seriousness and progression of disease, disparities in the onset of patient's disease occur before they receive health care (Williams, 2015).

The variances in health in racial and ethnic populations are related to the socioeconomic status (Williams, 2015). Because minority groups are disproportionately represented among the most economically oppressed in the U.S., they tend to be the focal point of conversations about health care access. In addition to the statistics on minorities, Americans are only getting 55% of the medical care that is recommended for illnesses (Frist, 2005). When researchers investigated the outcomes associated with socioeconomic status, race, or geography, the results revealed that the system wide challenges are even greater (Frist, 2005).

The causes of disparities in healthcare in the minority community are vast and the major causes are attributed to societal attributes (Betancourt et al., 2003). It is challenging to isolate racial and ethnic disparities in care and treatment. The disparities among minorities are not originated in mental health, but in organizational social factors outside of the responsibility of any one agency (Dreachslin & Hobby, 2008). This challenge was highlighted by Fiscella et al. (2000), who stated that the paths by which socioeconomic status and ethnicity/race affect

patients and the health industry are complex, and include such factors as affordability, patient beliefs, geographic location to access, education, transportation, knowledge, racial harmony with patients and provider, literacy, patient attitude and preferences, and demands of work and child care.

Eradication of race and ethnicity in health disparities and health quality improvements are integral in in overcoming the health challenges (Frist, 2005). In the U.S., socioeconomic status and race are closely associated and make it challenging to delineate the racial and ethnic disparities caused by socioeconomic status (Frist, 2005). Social determinants such as inadequate housing, poor nutrition, educational and economic opportunity, environmental risk factors, socioeconomics, and race/ethnicity are causal to deleterious health and survival (Fiscella et al., 2000). Further, socioeconomic status correlates with lower use of health services, even for insurance holders (Fiscella et al., 2000). Individuals with lower status receive fewer diagnostic tests and immunizations such as mammograms and influenza vaccines (Fiscella et al., 2000). In addition, patients represented by a racial/ethnic group are predisposed to less intensive and lower quality of care (Frist, 2005). Elderly African Americans are reported to see specialists less frequently; receive less standard preventative care, substandard hospital care, and fewer costly technological procedures (Fiscella et al., 2000). The less intensive hospital care received by elderly African American includes cardiovascular and orthopedic procedures, lung resections, bone marrow and kidney transplants, and cesarean sections (Fiscella et al., 2000). Comparatively, Latinos and Asian Americans also obtain fewer mammograms, Papanicolaou tests, prenatal care, vaccinations, cardiovascular procedures, and analgesia for metastatic cancer and trauma (Fiscella et al., 2000).

With the documentation of the minority health disparities, stratification of disparities by quality assurance measures has impaired advancement in addressing them (Fiscella et al., 2000). These disparities in the delivery of healthcare pose a threat to health quality. Healthcare resources and funds are distributed by medical necessity, risk, and benefit (Fiscella et al., 2000). With the current quality assessments, health maintenance organizations (HMOs) can allocate resources to those groups with minimal risk and more positive Health Plan Employer Data and Information Set (HEDIS) ratings (Fiscella et al., 2000). The quality measure assessments currently do not account for disparities. An example is a hospital institution that touts the success of its cardiac program yet fails to report its reduced access to its effective treatment for minority patients (Fiscella et al., 2000). The unintended consequence is that health plans can selectively target enrollment for minimal risk members only (Fiscella et al., 2000).

The Department of Health and Human Services created specific policy mandating sponsored collection of data, systems to report data, including Managed Care Organizations, to include racial/ethnic categories (Fiscella et al., 2000). Much of the data derived on ethnic disparities is from national population samples, but it is suggested that actions to eliminate health disparities are best generated from regional data of healthcare organizations, providers, and communities (Sequist & Schneider, 2006). The Social Security Administration (SSA), in addition to, the U.S. Census Bureau has information on outcomes and healthcare processes and provide their collected data to governmental databases for analysis of health disparities (Sequist & Schneider, 2006). The government provides two types of data for those who buy or provide health care and data for the monitoring of healthcare (Sequist & Schneider, 2006). The SSA provides the Center for Medicare and Medicaid (CMS) ethnicity and racial data and the U.S. census provides extensive population estimates on socioeconomic data on race and ethnicity

(Sequist & Schneider, 2006). The databases include mortality, health prevention services, procedures to manage chronic conditions, quality of life scales, quality metrics, patient satisfaction reports, utilization of health status and services, health outcomes, unit of analysis, and race designation.

As research and the collection of data through technology advances at a rapid pace, the division between science and medical practice is enlarging, contributing to the public's concern of lack of access, appropriate treatment, unsafe practices, and use of health resources (Saeed et al., 2015). Healthcare leaders have the responsibility to prove the public with health outcomes consistent with current data and professional acumen (Saeed et al., 2015). The components of a health system including treatment guidelines, measurement-based care, care coordination, knowledge and skills management, and IT are all under the leadership's purview in improving health outcomes (Saeed et al., 2015). The divergence of what is medically appropriate and what is practiced is large. Patients diagnosed with minimal risk prostate cancer are recommended to employ a watchful waiting method to avoid the unnecessary active treatments (Saeed et al., 2015). However, only 20% of these patients receive the approach of watchful waiting and 80% undergo more aggressive treatments (Saeed et al., 2015). The example is consistent for preventative, acute, and chronic conditions throughout health care across age groups and geography (Saeed et al., 2015). As these practices are inconsistent with medical evidence, there is mounting pressure among health leaders to demonstrate competence and positive outcomes.

Saeed et al. (2015) also found that practice guidelines and educational interventions alone do not influence physician practice behaviors as their cause is multifactorial and complex. One cause is the plethora of knowledge and how rapidly it grows. The rate of the knowledge growth demands physicians spend 25% of their time managing information that is expected to double in

three years. Clinicians maximize treatment outcomes by staying abreast of the treatments and methods proven to generate the best patient outcomes in recovery and remission.

Another challenge for health leaders in sorting and applying the data currency is not having the authority to dictate how providers attend to their patients. Because of the challenges in outcomes, governmental organizations have required process and outcome measurement in order to receive federal funding (Saeed et al., 2015). Outcome monitoring is aligned to patient goals, progress reports, and motivation of physicians to further improvement in treatment for each treatment interval (Saeed et al., 2015). The useful data mined is accessible within a patient's medical record and available for measurement-based care and monitoring treatment outcomes.

Leaders have to play a part in how the organization collects and analyzes outcome data to impact clinician's efficacy, including measures of performance in outcomes, and provide the physician perspective if treatment outcomes are changing over a period of time (Saeed et al., 2015). Thus, data collection and analysis that are communicated effectively can aid a medical group's strategies in patient outreach as well as provide longer term outcome measurements to achieve patient goals (Saeed et al., 2015).

There are limitations in how individuals report their race during data collection. Self-reporting and the designation of race by those who register patients may misperceive their race and inaccurately record it (Sequist & Schneider, 2006). Variations in the methods of classifying race can impact interpretation of research (Sequist & Schneider, 2006). Misclassification of non-black minorities can bias statistics of health status or mortality. The small sample of non-black minorities, such as American Indians, cause challenges in evaluating health care delivery and outcomes with certainty, in addition to the clustering of minority groups in certain geographic locations in the country (Sequist & Schneider, 2006). Due to the limitations, issues in

methodology must be considered in data collection on health disparities. The validity in classification on race/ethnicity, sample size, unit of analysis, and availability of cultural or socioeconomic characteristics on individuals should be considered (Sequist & Schneider, 2006). Limitations in sample size, missing data, and measurement errors can lead to problems in data collection. The small sample sizes reduce the researcher's capability to measure the disparity in socioeconomic and racial subgroups nationally (Bilheimer & Klein, 2010). The challenges broaden in data collection for communities and states where the need to solve for disparities are most common (Bilheimer & Klein, 2010).

The Health Information and Technology (HIT) Committee originated from the American Recovery and Reinvestment Act of 2009 (Bilheimer & Klein, 2010). The HIT committee was tasked to recommend new standards for implementation and certification for an infrastructure for health information technology (Bilheimer & Klein, 2010). A current policy originating from the HIT was an initiative on the topic of electronic health records (EHRs) that addressed the non-reporting and non-standardized approach to race and ethnicity in medical recording (Bilheimer & Klein, 2010). The health information infrastructure would collect data self-reported on ethnicity, language data, and race that could be shared with healthcare organizations with strict privacy protections (Bilheimer & Klein, 2010). Through the EHR and new policy of meaningful use objectives now require medical providers enter data on patient's language, race, gender, ethnicity, and insurance type for 80% of their patients (Bilheimer & Klein, 2010).

According to Fiscella et al. (2000), reimbursement should be linked to the socio-economic elements and racial characteristics of the enrolled population (Fiscella et al., 2000). In Great Britain, higher reimbursement rates are disbursed to areas of higher need in deprived communities (Fiscella et al., 2000). This strategy helps to abridge the costs of quality

improvements to eliminate disparities for caring for patients with higher morbidity (Fiscella et al., 2000). Under the new health care reform, collection of data is included as physician remuneration as an incentive payment for improving the quality of healthcare, state and federal regulations, funded medical programs, requirements for accreditation, and performance standards (Bilheimer & Klein, 2010).

Much of the research in health disparities is generated from federal databases. The government sets the standard in data collection for federal programs and the data for the growing ethnic population in the U.S. must accurately account the race and ethnicity. The data provide a valuable resource for health care leaders those responsible for policy to improve disparities for all. Healthcare organizations and their complexity mandate that leaders are equipped with a depth of skills and competencies (Saeed et al., 2015). Disseminating new knowledge and building a system to track the data ensure physicians can assimilate and apply the knowledge (Saeed et al., 2015). Comprehending the barriers to change and how change is managed lend to development of skills as healthcare professional roles change or in the need to stimulate behavior change in patients and physicians (Saeed et al., 2015).

Social Equity

When evaluating the educational barriers in healthcare in the U.S., consideration of the racial-ethnic achievement gaps is vital to enacting change. The African American and Caucasian achievement gap impacts today's students and the generation with which they are affiliated (McKown, 2013). The gaps apply to differences in school readiness and academic achievement. According to statistics on readiness and achievement, Asian Americans outperform Caucasian students, and Caucasian students score better than African American and Latino students (McKown, 2013). The gap in early child through elementary education grows and scores are

lower for African American students compared to Caucasians (McKown, 2013). This problem is attributed to societal problems correlated with wages and types of jobs that influence racial gaps in socioeconomic status (McKown, 2013).

According McKown (2013), the causes believed to influence the achievement gap is the genetic endowment and stereotype threat depressing African American student's test scores. Many of these accounts are discounted as they do not account for the multifactorial plausible elements. Social equity theory (SET) describes societal conditions that may explain racial-ethnic gaps and mean variances in achievement in racial-ethnic groups (McKown, 2013). SET proposes four distinctions on the genesis of achievement gaps in ethnicity and race. The first gap describes dual classes of social processes that derive achievement gaps: signal and direct influences. Direct influences distribute differently to race groups and signal influences are alerts to inform about negative expectations of children's racial ethnic group (McKown, 2013). Direct influences promote academic achievement and research indicates that parental relationships influence pre-academic and academic outcomes (McKown, 2013).

Data indicate that irrespective of income received, Hispanic, African American, and Native American providers usually serve in low economic communities than Caucasian physicians (Cohen et al., 2002). According to Betancourt et al. (2003), in the public health reports, minority patients who have similarities with their providers have better reported satisfactory and improved individual-rated quality of healthcare. Additional work has proven that ethnic patients prefer physicians of their same race or ethnicity regardless of community or other geographic factors (Betancourt et al., 2003). In addition, patients reported increased satisfaction when their medical providers use a participatory and inclusive style for making decisions. These

distinctions can be critical to patient outcomes and are necessary for medical leadership and policy makers to recognize.

Frank (2007) studied the need for leadership change in healthcare and defined medical leadership as physicians representing agents of change and improvement having authority for clinical decision making. Frank (2007) researched the dynamics of health leadership in Canada where leaders are forming into professional teams within the organization to implement change and drive outcomes. The team approach by leaders ensures the timely access to the highest care and contributes to quality.

As access to healthcare disproportionately affects the diverse groups of the U.S. population, the role of medical leaders as a team of providers improves access for patients, provides clinical expertise, ensures healthcare is deployed to best serve the population, and may improve healthcare outcomes. These inter-professional healthcare teams use a team approach identifying clear roles for medical leaders (Frank, 2007). The physician role has shared decision making and respect for diversity, while applying their medical expertise. Additional tenets of the Canadian approach to medical leadership in improving the patient-centered approach is the ability to facilitate the doctor-patient relationship in communicating before, during, and after visit; employ health advocacy for expertise and to ensure the health and wellness of patients; recognize and respond to community health needs and determinants; integrate participants in making decisions about allocation of resources; commitment to professional lifelong learning; and commitments by health leaders to the health and wellbeing of individuals and society by ethical medical practice (Frank, 2007).

In addition to seeking more minority representation in leadership, there is a call for more diversity in education of healthcare professionals. The purpose is to increase the cadre of

medically trained executives and policymakers to lead in higher level management positions to contribute to health reform and critical issues (Cohen et al., 2002). The ability of a diverse pool of talent in public, private, and governmental agencies to make strategic decisions would be advantageous for a diverse segment (Cohen et al., 2002).

Many researchers have explored the barriers in cross-cultural relationships between physicians and their patients. The researchers have reported that minority patients report lower quality interactions with Caucasian physicians than Caucasian patients (Saha, Arbelaez, & Cooper, 2003). Further, minority patients also stated that they prefer having a physician of their own race/ethnicity and rated these physicians as having better quality in relationships and interpersonal care. The studies have not proven if race and relationships have an impact on health disparities outcomes (Saha et al., 2003).

Saha et al. (2003) did report a low level of cultural sensitivity from Hispanic and Asian patients and a positive correlation of metrics of cultural sensitivity and quality of physician-patient interactions. The discordance was not found to be a result of racial differences but a factor of patient's health literacy and cultural sensitivity (Saha et al., 2003). Furthermore, the research established health literacy as a significant distinction in the quality patient-physician interaction, satisfaction with care, and their utilization of healthcare resources (Saha et al., 2003).

Researchers have correlated low health literacy as a predictor for being uninsured (Adepoju et al., 2015). It is estimated that 9% of the population are limited in their English proficiency, making health care language a challenge and important issue to address (Adepujo et al., 2015). More than 50% of adults have difficulty with common healthcare terms and lack understanding of the cost of healthcare services (Adepoju et al., 2015). This lack of comprehension can inhibit medical care, health outcomes, and quality among the limited English

proficiency population (Adepujo et al., 2015). The authors suggested that the responsibility rests with both parties in reducing the cross-cultural barriers. Patients must educate themselves on the language and culture of health as physicians enhance their skills in cultural competence (Saha et al., 2003). To continue progress in eliminating health disparities, continuous improvement in improving cultural competence, social attributes, and cultural and linguistic deficiencies must be addressed to maximize patient engagement, access, and equity in care.

Geography

The alteration in the racial emblem of the U.S. population accounts for racial and economic gentrification in the landscape of neighborhoods (White, Haas, & Williams, 2012). The percent of communities that are isolated by race and ethnicity and socioeconomic status require further research (White et al., 2012). Researchers reported that racism in the U.S. contributes to lack of social contributions form minority groups and material resources (Kennedy, 2013). There is a scarcity of information available to diverse populations that negatively impose on their quality of life (Kennedy, 2013). The lack of resources has been associated to individual income as well as the distribution of income (Kennedy, 2013). African Americans and other minority groups reside in majority racially segregated communities. The segregation may contribute to historically low socioeconomic status and poor health because of racism and discrimination (Kennedy, 2013). The ethnic communities are prone to be exposed to health risks such as unhealthy food options, alcohol, and tobacco. There are also issues regarding accessibility to housing and health care (Kennedy, 2013). There is evidence to support that availability of medical resources reflect the geographic distribution of the minority population (White et al., 2012). The lack of resources in the minority community correlates to its effect on health care as these communities have less access to health service organizations like hospitals

and pharmacies (Kennedy, 2013). The hierarchy of racial/ethnic segregation in the U.S. surpasses economic segregation (White et al., 2012). As policies are enacted to end segregation and institutional discrimination, the former practices have perpetual implications for individuals and community (White et al., 2012). Prior to the Civil Rights Act of 1964, African Americans were entitled to receive separate but equal, access to facilities. With respect to health care, African Americans and Caucasians received care in separated locations or on different floors (White et al., 2012). The Civil Rights Act of 1965 also prevented medical segregation by institutions that received federal funding. This act was further supported by the development of Medicare in 1965 (White et al., 2012). The disparities in education, employment, physical and cultural features of neighborhoods have implications for individual and community health (White et al., 2012).

These factors can prevent the purchase and entry to equitable health care services and qualified health practitioners. For example, poor and undeveloped communities may not have the advantage of attracting primary care and specialists (White et al., 2012). Additionally, the supply of medical providers mirrors the depth of the segregation of an area and plays a significant role in in health care disparities (White et al., 2012).

In Norway, where healthcare leadership is emphasized, the availability of leadership training for undergraduate medical students is lacking. Physicians in general practice receive two days of leadership training and community medicine practitioners train for six days. Physicians who practice in rural areas feel the training is not sufficient and tend to use their clinical training and problem-solving skills (Hana & Kirkhaug, 2014). Practice styles in Norway differ than in the U.S., where physicians and support staff are organized into teams and the leader is a physician who has a clinical and public health position (Hana & Kirkhaug, 2014).

Variance in health financing, purchasing, and the disbursement of health resources are also affiliated with geographical locations. Many health institutions that reside in poor neighborhoods and manage treatment for uninsured and inadequately served are in dire financial conditions and disbanded operation (White et al., 2012). These closures result in minimized access and limitations in patient care (White et al., 2012). Additionally, physicians who practice in diverse neighborhoods are dealing with more administrative, clinical, and logistical issues. These physicians treat patients who have a higher proportion of government subsidies, such as Medicaid, and receive lower reimbursements for services rendered (White et al., 2012).

Another critical aspect of health care is palliative care options and services. Disparities in availability and utilization of palliative services may be causal to the immense history of segregation (White et al., 2012). As the use of palliative care in the minority populations may be attributed to preference, utilization of palliative options is lower in African American and Hispanic neighborhoods (White et al., 2012). Also, nursing homes in these geographies are associated with poor staffing, inspection deficiencies, and greater financial risk (White et al., 2012). The shaping of policy to address communities underlined by segregation has consequences that impact the healthcare system on a broad scale. From utilization to access to care, the lack of diversity historically and today has undertones that limit entry to health services and equality in treatment of patients and use of health care services (White et al., 2012). The research into geography and characteristics of location are vital in in reducing health disparities and identifying paths for intervention and creation of policy to enact change.

Healthcare Leadership

Leadership is defined as a critical role in healthcare. No longer is it accepted for medical practitioners to ignore the necessity of effective leadership in today's medical environment.

Western medicine is experiencing a convergence of forces reshaping the health care system in an era of financial incentives and expectations for quality. Healthcare has more demands for regulation, affordability, access, improved care, and evidence-based decision making (Frank, 2007). Leaders in healthcare have evolved from being the leaders of small practices to becoming captains of inter-professional teams of subspecialists, care-models, and essential staff with responsibility to achieve optimal patient care and outcomes. The health care system in the U.S. must provide a responsive and dynamic system with a staff of providers that is equipped to operate in constant organizational and policy change (Oliver, 2006). Formerly, leaders in healthcare—as in most industries—were perceived as managers with recognized authority (Oliver, 2006). With the rapid pace of change in the health industry, leaders are expected to manage the organizational, policy, and patient mandates. Additionally, challenges confronting health practitioners and leaders in leadership diversity, cultural competence, communication, and health literacy place an increased demand on these roles. Today, for leaders to enact and implement change, they must demonstrate the competencies of leadership expertise in clinical decision making and patient focus (Cooper, 2003).

Diversity in Leadership

The influencers of policy, physician structure and leadership must be inclusive at all levels of the healthcare process (McAlearney, 2006). According to the Institute for Diversity in Health Management, minorities make up 12% of executive healthcare leaders and 17% of first-line and middle managers in health care companies (Bowen, 2014). In the absence of effective leadership in diversity, even culturally competent physicians will fail to perform to their maximum capabilities (Dreachslin & Hobby, 2008). Diversity in leadership can positively impact patients at a clinical level and potentially at an Increasing the numbers of minority health

professionals could help ensure strategic decisions and ensure policy is developed and enacted tailored to the concerns of ethnically diverse societies. In the healthcare executive suite, diverse leaders are a rarity in the healthcare industry. From the upper echelons of insurance firms, hospital systems, devices, and the pharmaceutical arena the diverse makeup of employees in healthcare can be attributed to the delivery of care for their diverse constituents. In the Case for Diversity in The Healthcare Workforce, the authors argued that minority representation in healthcare is critical to provide competence of care for cultural significance in the nation's growing minority communities (Cohen et al., 2002). In the behavioral health discipline, the majority of administrative and executive leaders are non-Hispanic Caucasians (Rosenberg, 2008). Rosenberg (2008) states that the lack of diverse leaders will contribute to the large gap in health disparities in ethnic and racial populations.

According to the Census Bureau, the demographic composition of the U.S. is quickly changing. The majority of non-Hispanic Caucasians represent 50% of the population, Latinos represent 24%, and Asian composition has grown from 4% to 8% since 2015 (Rosenberg, 2008). The critical need of healthcare leaders is how to design the organization and delivery of care to meet the needs of language, culture, and religious beliefs (Rosenberg, 2008). For mental disorders, the call is for cultural competence in extending the advances in science to treating and understanding addictions and mental disease (Rosenberg, 2008).

While the incidence of mental disease is similar for African Americans and Caucasians, minorities undergo a greater disability and burden of disease and receive less treatment and quality of services. Minorities are growing in population as their inequality of income and economic opportunity is declining (Rosenberg, 2008). In a 2006 survey of the healthcare industry, 34% of minority leaders reported that they believed the opportunities for diverse

leaders improved, while 73% of Caucasian agreed that minority opportunities improved (Rosenberg, 2008). In addition, 80% of Caucasian leaders reported minorities are now well represented in healthcare compared to 34% of minority leaders (Rosenberg, 2008).

In contrast to Rosenberg's (2008) statistics on demographics of health professionals, Dreachslin and Hobby (2008) reported that the racial and ethnic representation in health care does not equate with the composition of the labor force. African Americans and Hispanics comprise 25% of the labor force, while less than 12% are physicians, speech pathologists, and physical therapists. Less than 16% of medical and healthcare managers are African American or Hispanic/Latino and less than 5% are Asians (Dreachslin & Hobby, 2008). Dreachslin and Hobby (2008) concluded that, in addition to minority representation in the healthcare labor force, drivers such as the social influences of shared attitudes, education, experience, and systemic disparities play a role. Further, a solution to the career disparities lie at the organizational level, supported by leaders who drive concordance in care, attitude, and cultural/linguistic skill set that advances the organization with competence (Dreachslin & Hobby, 2008).

When surveyed on the lack of commitment by management in diversity recruitment, retention, and leadership development, 90% of minority leaders reported lack of commitment was the cause by senior leadership (Rosenberg, 2008). Researchers have found that competent training and development programs are the primary reasons employees accept offers and establish tenure in their roles (McAlearney, 2010). Retention is especially important in the healthcare industry due its competitiveness in hiring and retaining talent (McAlearney, 2010). Leadership is considered a competitive advantage for corporations with the ability to improve leadership competencies through training and development. The ideal leadership development curriculum is designed to change behavior that supports the strategic objectives of the

organization (McAlearney, 2010). In 2007, Senator Jack Reed introduced legislation known as the Community Mental Health Services Improvement Act to promote diverse mental health employees working in states, Indian tribes, or tribal organizations and implement innovative programs to address the needs in behavioral health in targeted shortage areas in mental health (Rosenberg, 2008). The National Council on Health committed to drive a culturally, racially, and linguistically diverse system of healthcare to provide mentoring and leadership training to eliminate disparities in care (Rosenberg, 2008). The three pillars the council adopted to end the disparities in care and promote cultural sensitivity were for safe and effective health care, patient-centered focus, and efficiencies in timely and equitable care (Rosenberg, 2008). The U.S. is a melting pot and the new norm is to experience diversity in care. Programs to address disease, irrespective of disease state, would be advantageous for leaders to embrace.

The Sullivan Commission (Sullivan, 2004) stated that long term reforms must take place at the pre-college education levels and with affirmative action initiatives. Students in minority communities are not receiving academic preparation and/or guidance to prepare them for potential future careers in medicine. Although affirmative action has its problems, consideration needs to be given to initiatives that factor race in the admissions process for medical schools across the country.

Sullivan (2004) reported that minority representation of the future health professionals does not match the proportion of the American population that they make up. In New York State in 2007, the total number of African Americans, Hispanic/Latinos and Native Americans comprised 35% of the population, but only a tenth of the medical workforce, 13% of nurses, and 7% of dental practitioners (Sullivan, 2004). These figures from New York are indicative of a

nationwide problem relating to the underrepresentation of diversity of minorities in health profession careers.

With respect for service delivery, researchers have found that almost 45% of African Americans and 24% of Hispanic medical practitioners in office practices in California treat patients with Medi-Cal as the primary insurance, as opposed with 18% of Caucasian physicians (Betancourt et al., 2003). A need to support diversity in medical education and practice is for improvement in access to qualified medical providers for the underserved (Cohen et al., 2002). California's shortage of healthcare providers is in areas of high minority populations (Cohen et al., 2002). To narrow the gap in in diverse health professionals, education proponents argue that disparities at the pre-college level should be addressed (Cohen et al., 2002). When students across geographies have access to high-quality primary, secondary, college, and professional education, the makeup of post-graduate medical education and training could reflect the general population (Cohen et al., 2002). Shifting America's K-12 education will cause a restructure in education and health policy to challenge the educational system (Cohen et al., 2002).

Variance in care continues to plague the healthcare system as the community's leaders work in are becoming increasingly diverse. Leaders must assume the responsibility and make the importance of diversity a priority (Bowen, 2014). A landmark study of U.S. hospitals in 2013 concluded that minorities represented only 14% of hospital board members (Bowen, 2014). In addition, minorities represented 12% of executive leaders and 17% of mid-level managers in healthcare (Bowen, 2014). Greater success can be realized by operationalizing strategic, organizational, and personal methods to ensure progress.

Strategically, data to identify disparities in treatment and outcomes for ethnic and racial groups and inclusion of goals can narrow the gaps (Bowen, 2014). Organizationally, diversifying

management through recruitment of diverse candidates can be an entry point. Lastly, leaders can improve their self-awareness of the role diversity plays in their own organizations (Bowen, 2014). Diversity frameworks impact business operations and serve as models for healthcare organizations to lead in cultural competence and patient-focused care that reduces unequal treatment in healthcare (Dotson & Nuru-Jeter, 2012). Organizations that are ethnically and racially diverse outperform racially homogenous organizations in quality and financial outcomes. Two of the drivers for this success are the leaders and culturally competent care (Dotson & Nuru-Jeter, 2012). Cultural competence has emerged as a strategy for quality improvement and to remove the disparities in healthcare (Betancourt, Green, Carrillo, & Park, 2005). The cultural competence goal is to develop a method and team to bring high quality of medical care irrespective of language proficiency, ethnicity, race, or culture (Betancourt et al., 2005). Dotson and Nuru-Jeter (2012) identified benefits for the investment in cultural competence in driving quality, care, and outcomes:

- Demographic changes in the landscape of the workforce in health care and participant needs influence companies to engage an ethnically diverse workforce pool to retain and recruit competent talent.
- The global economy drives incentives for healthcare companies to maintain diverse teams and deliver quality and competent care to diverse patient populations.
- Diversity drives innovation, creativity, group problem solving, competition, financial, and quality outcomes. (Dotson & Nuru-Jeter, 2012, pp. 36-37)

It is the commitment from organizational leaders to drive the change by implementation of diversity management initiatives and to make the care for diversity leadership in healthcare

(Dotson & Nuru-Jeter, 2012). In the U.S, policy has shaped the context for leadership diversity in healthcare. The Civil rights Act of 1965 provided organizations were prohibited to discriminate against its citizens based on race, color, or national origin (Dotson & Nuru-Jeter, 2012). Federal funding mandated these policies and fair employment practices be adhered to. The Heckler Report incentivized clinical research on reducing disparities in education, health information, health service delivery, health professional's development, and data development (Dotson & Nuru-Jeter, 2012). The historical laws and policies provided strategies and a foundation for health equity. The healthcare system and health organizations have not fully realized the link between health equality and financial gain (Dotson & Nuru-Jeter, 2012).

Cultural Competence

Cultural competence and performance emerged recently as an approach to improve quality and mitigate disparities. Cultural competence includes aspects of patient-centeredness of focus on the patient (Cooper, 2002). Constructs in cultural competence are awareness, skills, desire, encounters, and knowledge (Cooper, 2002). Cultural competence involves the deliberate and cognitive process where healthcare provides show sensitivity to values, lifestyles, and beliefs of their patients. When language, religious, cultural, gender, race, and ethnic disparities are not recognized in the delivery of patient care, they add on to the disparities and inequities and mitigate trust and healing (Dreachslin & Hobby, 2008). It also includes the emotional intelligence reflecting personal biases of other cultures (Cooper, 2002). Cultural knowledge is the process of gaining a foundation and knowledge of global views into cultures, specific to physical, biological, and physiological distinction among ethnic groups (Cooper, 2002).

It is posited that improvements in quality in the U.S. healthcare system will not only benefit the minority populations but will provide improvements in the healthcare system for all

U.S. citizens (Betancourt et al., 2003). By improving provider-patient communication, differences in race, ethnicity, and culture of the patient can be addressed (Betancourt et al., 2014). The impact to healthcare is important as the U.S. is becoming increasingly diverse. These patients will require their providers to be aware of differences in how health symptoms are presented, seek care at various levels of their disease, and express different beliefs that may impair compliance (Betancourt et al., 2014).

Researchers have found that the provider-patient sociocultural difference of that engagement has a correlation to patient satisfaction, clinical decision making, and health outcomes (Betancourt et al., 2014). When the sociocultural differences between provider and patient are not appropriately managed, lower quality of care and health disparities can occur (Betancourt et al., 2014). The sociocultural differences between the interaction of the patient and the health care provider can be defined as a clinical barrier. Health providers cannot be culturally competent by educating themselves via text resources (Cohen et al., 2002). Health providers should intersect their education in cultural environments emblematic of the cultural and racial patients they serve (Cohen et al., 2002). Examples of the misunderstandings are when the practices of the patient are not fully understood or accepted. The patient's natural remedies, trust in physicians, health beliefs, and family involvement in health decisions differ from what is taught in the mainstream health system (Betancourt et al., 2003). The ability of the health professional to engage with individuals from divergent backgrounds transcends their personal beliefs and views and allows them insight through the perspective of their patient (Cohen et al., 2002).

Between the years 2003 and 2006, the indirect and direct expenditures due to health disparities in the U.S. were $1.24 trillion (Betancourt et al., 2014). Factors contributing to these

costs included medical errors, avoidable hospital admissions, prolonged hospitalizations, readmissions, and over and underutilization of services (Betancourt et al., 2014). Researchers in cultural competence have suggested it is also effective for clinicians, providers, and health care leaders to learn about the demographic and historical experiences of a culture and group acculturation in addition to the beliefs, values, and customs (Betancourt et al., 2014). Thus, cultural competence has developed into skills-based learning around patient-centered care in values, patient preferences compassion, empathy, and responsiveness to needs.

In addition to cultural competence strategy to focus on the provider, the focus should also be on quality improvement. Culturally competent quality initiatives are created to improve care by tailoring the initiatives to highlight cultural, linguistic competence, medical procedures, and access to health care (Betancourt et al., 2014). The quality interventions may also have a role in reducing health disparities by narrowing the root causes. Betancourt et al. (2014) described cultural competence interventions as either organizational or structural. According to these authors, organizational cultural competence interventions are intentions for health leaders and their employees in the health system to be diverse and represent its population (Betancourt et al., 2003). Examples of organizational interventions are diverse employee recruitment in medicine and medical schools (Betancourt et al., 2003).

The structural competence interventions are initiatives to grant full access to quality healthcare for all members within a healthcare delivery system (Betancourt et al., 2003). Furthermore, evidence exists to support that outcome disparities are a result from inequities in the healthcare system structure (Wong, 2015). Structural interventions are the most researched in improving language barriers and the provision of culturally accurate health education resources to improve patient's acumen in medical interventions (Betancourt et al., 2003). Structural

barriers also include areas that limit access to care, such as prolonged waiting times, intake processes, referral processes, and continuity of care (Betancourt et al., 2003).

As a response to federal funding and new regulations, healthcare organizations enacted change in language access for non-English speakers at a cost of $268 million (Dotson & Nuru-Jeter, 2012). In a study by Gertner et al. (2010), cultural competency is defined as tailoring needs to address cultural, linguistic, and social needs for patients with diverse views, beliefs, and behaviors. Gertner et al. (2010) used an environmental scan, community demographic, and patient data to develop a strategic plan to focus on demographics, language- appropriate services, employees, training, and education to undertake a transformational approach to improve cultural competency in a health system. They hired interpreters, trained staff to interpret, provided a year-long training program to develop leaders to provide innovative community health, improve quality in health and outcome measures, and provided patients with cultural meals (Gertner et al., 2010). In addition, buy-in from leaders and staff was accomplished through a joint strategic plan and creation of a cultural awareness mission. Using standards from the joint commission recommendations for culturally competent care, Gertner et al.'s (2010) research showed equitable care does not lack quality due to an individual's gender, ethnicity, geographic location, and socioeconomic status.

The combination of gender, partnership, and race in the physician and patient relationship shows that diversity in the healthcare workforce improves levels of patient participation in decision making and overall satisfaction (Cooper, 2002). This study showed a marked enhancement of communication when physicians and patients belonged to the same ethnic group. Communication should not be downplayed in a context that is as important as healthcare. Racial and ethnic homogeneity with a healthcare system situated in a diverse social context is a

recipe for strained patient-physician engagement. Racial and ethnic diversity must be pursued to promote quality healthcare service to patients. But researchers are also advancing the importance of providing culturally competent health care providers. Medical providers who connect with patient cultures, norms, language, values, and home life help providers communicate effectively with patients about their health and individualized care (Cohen et al., 2002). As evidence links cultural competence strategies to improved patient health outcomes, skills training for physicians in the role of self-awareness, biases, linguistics, literacy, and patient satisfaction must be adopted and implemented to begin to address the disparities in care, equity, and outcomes in underserved populations.

Communication

Health communication is relevant in the delivery of care and for the strength of public health (Kreps, 2006). Effective strategies in communication between medical providers are critical for quality care (Frist, 2005). Core elements of communication to include ethnicity, gender, and collaboration in the patient-physician relationship show that diversity in the healthcare workforce improves levels of patient participation in decision making and overall satisfaction (Cooper, 2002). Cooper's (2002) study showed a marked enhancement of communication when physicians and patients belonged to the same ethnic group. Communication can be used as a tool to promote health prevention, health risks, healthy behaviors, early screening and detection, accurate diagnosis, treatment, and palliative care (Kreps, 2006). Gaps in conveyance of information lead to breaks in care and in health promotion, especially for patients exposed to disparities in care and outcomes (Kreps, 2006). Ethnic minority patients with poor health or elderly patients and those with an elementary education report a low amount of participation at physician appointments (Cooper, 2002). African

American and other minority patients with common racially disharmonious relationships with physicians, report low participation in health decisions, low provider engagement, and lower rates of satisfaction in their healthcare (Cooper, 2002). As reported by Cooper (2002), there are three strategic pillars to improve multicultural communication: (a) services to address language needs such as interpreters and competent linguists in medical literature; (b) the inclusion of cultural likeness in care staff with similar backgrounds, incorporation of backgrounds, traditional treatments, and local health employees; and (c) medical group accommodation, i.e., location, hours , physical environment, and culturally sensitive interaction with the patient population and their preferred remedies. The culturally sensitive approaches are suited to affect the communication between patient and their provider in understanding and improving the ethnic and racial disparities in health care (Cooper, 2002).

Social class may also be a contributing factor to how physicians communicate with patients. Cooper (2002) found that sociolinguistic distinctions and linguistic skills vary across social classes. Middle-class communicators are verbally explicit, while working-class communicators are more implicit and use nonverbal signals (Cooper, 2002). It is also plausible that physicians also communicate based on their social class. The similarity of a patient's and physician's social classes can assist in communication (Cooper, 2002). However, communication can be impeded when a physician's poor background conflicts with patients of a higher social status (Cooper, 2002). Gender, race, and partnership in the physician-patient relationship show that diversity in the healthcare workforce improves levels of patient participation in decision making and overall satisfaction. Researchers have also found a marked enhancement of communication when physicians and patients belonged to the same ethnic group (Cooper, 2002).

Kreps (2006) found that focus on goals accomplishment in the continuum of care can remove the barriers of disparities in outcomes through the incorporation of sensitive, adaptive, and strategic health communication programs. Culturally sensitive communication that avoids biases, elicits respect, and augments creation of synergistic health care partnerships, has been determined to significantly influence the quality of healthcare and promotion in underserved populations (Kreps, 2006). Strategic programs and health promotion campaigns encourage participation in prevention and screening programs. To be effective, the campaigns must address important cultural factors and be transmitted by specific channels for different audiences (Kreps, 2006). The communication channel must be familiar and trustworthy by the audience. Kreps (2006) stated that culturally framed messages are beneficial at impacting cancer prevention and detection and screening actions for low-income African Americans and minority medical consumers. Targeted health communication strategies facilitate the delivery of messages to align to the demographic, cultural, and psychographic perspectives of health purchasers. According to Kreps (2006), effective communication strategies to impact at-risk patients utilized trustworthy and familiar channels such as radio, television, schools, churches, and work organizations.

Health Literacy

Low health literacy is a growing issue in healthcare and according to results from the National Adult Literacy survey; approximately 90 million U.S. adults are challenged reading written text (Frist, 2005). Functional illiteracy contributes to inefficient use of health resources, preventive services, access to health information, medical decision making, and increased costs (Adkins & Corus, 2009). The issue of poor literacy and the relationship to patient care, when viewed in the context of health, reflects on patient outcomes (Cooper, 2002). The health-related test of Functional Health Literacy Assessment (TOFHLA) reflects specific metrics to assess the

patient's skill in performing health-oriented tasks to include reading and computation skills. Among the tasks evaluated are taking medication, maintaining appointments, adhering to instructions for test procedures, and providing consent. Results from TOFHLA indicated approximately 33% of low income hospital patients were assessed as illiterate, while 13% were partially illiterate (Cooper, 2002).

With the amount of literacy in the general population, it is probable that physicians will interact with patients of lower literacy capability (Cooper, 2002). The challenge is for physicians to recognize these patients and be aware of the effect of literacy on patient health outcomes. Societal expectations on reading and social acceptance may silence patients and discourage their actions in requesting information or aid (Cooper, 2002). Patients with limited health literacy and chronic illness have low knowledge of their disease management compared to individuals with higher health literacy (Frist, 2005). With respect to health outcomes, racial disparities are related to communication problems and result in unequal access to health information and participation in health care decisions (Kreps, 2006). Kreps (2006) discussed how the development of training programs for healthcare providers to encourage culturally competent communication has impact in improving health communication and reducing health inequities. A third of the U.S. population has challenges with health-related actions as reading drug labels, adhering to prescription directions, and using charts (Adkins & Corus, 2009). Low literacy in medication noncompliance amounts to $177.4 billion annually (Adkins & Corus, 2009). The challenge is for physicians to recognize these patients and be aware of the effect of literacy on patient health outcomes (Cooper, 2002).

Researchers in health literacy characterize health literacy as a social practice incorporating reading, writing, and personal/social assets aimed at improving health (Adkins &

Corus, 2009). Health literacy barriers that undermine understanding between patients and providers can also be addressed through sensitive and culturally adapted communication. The communication should incorporate language and examples for all to understand and provide for feedback to assess comprehension (Kreps, 2006). A strategy employed by medical professionals is to address knowledge deficiencies and not make assumptions of good functional literacy (Adkins & Corus, 2009). Health organizations can improve health outcomes by providing education for providers on assessing literacy, and integrating cultural, beliefs, values, and educational backgrounds of their patients (Adkins & Corus, 2009). In addition, resources such as videos, picture books, multimedia, and plain language can address most of the literacy problems (Adkins & Corus, 2009). Focus on the development of strategic and targeted approaches in communication across channels and cultural sensitivities has the capability to improve the quality of health and reduce inequities in care.

Health Leadership Framework

Healthcare leadership is closely aligned as transformative leadership as it addresses the emotions, trust, values, ethics, standards, and goals of the organization. Research by Oliver (2006) addressed the impact empowered leaders have in driving goals. Oliver (2006) believed empowered leaders in healthcare are key to organizational development. She studied the success of the National Healthcare Service (NHS) in the United Kingdom and the role of nurses in driving outcomes. The NHS, the guiding framework of the Affordable Care Act, provides free healthcare to four countries in the UK with the commitment and goal to deliver thorough health and rehabilitation services for prevention and cure of illness. Oliver (2006) espoused the eight leadership roles of healthcare in meeting the NHS goals. According to Oliver (2006), improving

organizational leadership should facilitate an effective implementation and accountability of changes to improve retention, reduce stress, and improves career advancement and satisfaction.

The traditional hierarchical approach in healthcare models, in which leadership was viewed as a management role, is no longer effective for managing change. Healthcare leaders are now recognized for task specific roles and the industry is becoming more complex and outcomes based. Oliver (2006) defined leadership roles influential in inspiring and leading change; the leadership roles in healthcare are described as follows:

- Teaching leadership
- Inspiring confidence in leaders
- Empowerment
- Performance improvements in support and clinical supervision
- Rewarding and recognizing individual contributions
- Awareness of service needs from a clinically structured environment
- Implementation of change
- Organizational support and the provision of a link with senior leadership and employees/team members in educating, developing, and supporting initiatives. (pp. 40)

As the healthcare process is transforming structurally, economically, politically, and legally, the demand of healthcare leaders is to guide the process while delivering on the health outcomes and delivery of care. The healthcare system is an entity that is experiencing transformation and is pressured to improve access and quality (Wikstrom & Dellve, 2009). Ensuring access and providing quality must be accomplished within cost efficiency targets (Wikstrom & Dellve, 2009). These goals create new situations for leaders as organizational goals

are task and responsibility oriented. These leaders who function within the process framed organizations, must also align to shared responsibility, boundaries, and real time practice issues.

In addition to organizational challenges for medical leaders, economic directives are often inconsistent with health priorities (Wikstrom & Dellve, 2009). Communication gaps between physician managers, organizational leaders, and department leads account for unclear direction and information that is contradictory. The shift in healthcare as a result of health reform and health drivers has encouraged the leaders' need to implement expeditious change. According to Kotter (1996), successful organizations will emerge to address the rapid pace and competitive environments with a new type of employee (Kotter, 1996). Successful leaders develop the competency to lead in complex and transitional environments and grow in their capacity for advancing transformation (Kotter, 1996). Research by Kotter (1996) indicated the significant incidence of change in organizations has increased over the past twenty years (Kotter, 1996). Kotter's (1996) eight stage process for organizations to effect major change was born from a process of thoroughly studying successful organizations. Kotter's stages performed in sequential order are driven by qualified leaders and have proven to drive transformational change in organizations.

Stage 1: Creating a sense of urgency. Establishing urgency addresses the complacency that can subvert change initiatives. It is critically important that decision makers be compelled to accept the change and commit to participate in the change vision (Kotter, 1996). The urgency also is associated with strong leadership, and creating a sense of urgency combats complacency, apathy, and the tendency to accept status quo (Kotter, 1996).

Stage 2: Creating the guiding coalition. Guiding coalitions and creation of the team are essential to anchoring innovative approaches in the reengineering, restructure, or retooling of

strategies. Four characteristics in the development of the guiding coalition are power of position, expertise, credibility, aligning of goals and leadership (Kotter, 1996). Additional drivers in coalition building are finding the best candidates, trust, and developing a common goal.

Stage 3: Developing a change vision. The development of a vision guides the employees to a perspective on language and the goal and on why they should be motivated to create that vision and policy implementation. This action step involves revisiting and clarifying the objectives stated in the policy recommendation and linking those to a desired change in society. Kotter (1996) created a vision to serve salient purposes, which detailed decisions and encouraged people to take positive and uncomfortable action.

Stage 4: Vision communication. A good vision is simplistic, metaphorical, repetitious, consistent, shows leadership by example, and allows two-way communication (Kotter, 1996). The vision also begins with a statement reflecting the dreams or needs in the marketplace. The vision must be effectively communicated within the partnerships and coalitions that have been established. The vision must be delivered to stakeholders, constituents, and decision makers after vetting by the guiding coalition. The communication of a vision is best disseminated in multiples mediums to include oral and written forms.

Stage 5: Empowering employees for large scale action. Employees are empowered to act by the removal of obstacles implementing change. Well-structured empowerment practices inspire people to effect change (Kotter, 1996). Best practices include:

- Communicate a realistic vision to employees
- Align structures to the vision
- Train employees for skill enhancement and empowerment
- Link data and personnel systems to the vision

- Address leaders who subvert change (Kotter, 1996).

Stage 6: Generating short-term wins. Short term wins provide proof and data that the imposed changes are effective and not deleterious to the organization (Kotter, 1996). Short term wins have the characteristics of:

- Being visible to many employees
- Unambiguous in their success
- Clearly are related to the change effort
- Fine tune the vision and strategies
- Undermine cynics
- Maintain leader support
- Drive momentum (Kotter, 1996).

Stage 7: Sustain acceleration. To lead change, leaders must have the ability to keep team members and partners active, energized, and purpose driven (Kotter, 1996). Without the motivation, teams may have reduced engagement towards the goal. Teams may also be influenced members who have not bought in and seek to draw them away. Active participation and focus on what is in it for each team member maintains focus and commitment (Kotter, 1996).

Stage 8: Institute change. The final stage in Kotter's (1996) framework is related to integration of a change. The iterative and recursive nature of policy implementation may require repeating Kotter's eight-step framework various times for the change to ultimately stick (Kotter, 1996). The overall process may exceed the initial timeframe for implementation and take longer than expected. Moreover, the nature of policy implementation demands adaptability as negotiating and bargaining are inherent to the process (Kotter, 1996).

Healthcare Strategies

As the burden of disease and incidence of injury escalate, there is a need to identify treatment strategies to improve the current health condition. Smoking, unhealthy dietary habits, and physical inactivity are causal to 33% of premature deaths (Ockene et al., 2007). Ockene et al. (2007) proposed that preventative and therapeutic services delivered to all through adequate treatment could mitigate the burden of disease. Positive progress has been implemented through a combination of preventative health measures and community and clinical interventions to impact behavior. The social-ecological framework introduces social behaviors and their influence on health care across many levels. The levels range from individuals, family groups, larger systems, the population, and ecosystems (Ockene et al., 2007). Targeting strategies are best aimed at each interrelated levels' impact on health and behavior (Ockene et al., 2007). Intervention strategies for the family, social groups, and the community are vital for impacting how people live and to provide individual support. Examples of social networks include churches, schools, YMCA, worksites, and places of worship (Ockene et al., 2007). Interventions can also target ethnicity/race, health condition, and geography where participants share a common interest (Ockene et al., 2007).

Policy interventions target the highest level of community intervention and the largest need for change (Ockene et al., 2007). Institutions like the criminal justice system, environment, agriculture, and healthcare regulation influence laws and regulations to ensure patient rights and to inhibit or support behavior (Ockene et al., 2007). The Massachusetts Tobacco Control Program (MTCP) was acknowledged by the Centers for Disease Control (CDC) for its development and implementation of coordinated treatment and control program QuitWorks to lower the use of tobacco (Ockene et al., 2007). The MTCP program interconnected media

platforms to influence public opinion and community norms, advocacy to affect local policy and regulations, and development of comprehensive smoking cessation treatment programs aligned to the CDC and PHS guidelines (Ockene et al., 2007). QuitWorks, still in operation today, was financed by the Massachusetts Department of Public Health and worked with all health plans to link patients, clinicians, and counselors. Its success was partly attributed to the use of mapping services using a social-ecological framework with complementary and coordinated efforts (Ockene et al., 2007). The integration of effective community and clinical setting strategies has proven to be a successful model. The framework can influence a wide audience and have applicability across therapeutic areas. The U.S. Department of Health and Human Services initiated a project implementing and evaluating the prevention of chronic diseases (Ockene et al., 2007). The program, Steps to a Healthier U.S., supported 40 communities to reduce the incidence and burden of diabetes, asthma, and obesity (Ockene et al., 2007). Linkages were made between the community-based organizations and healthcare providers in a collaborative approach to implement strategies, cost efficacy, and link resources into a network (Ockene et al., 2007).

The Institute of Medicine's Commission to End Healthcare Disparities recommended a four-step strategic approach to develop solutions to remedy healthcare disparities. First, based on the committee's strategies, policies must be aimed at disease prevention, health education, medical, mental/behavioral health, and public concerns (Smedley, Stith, & Nelson, 2003). Data collection with accuracy on race, ethnicity, and language should be monitored and collected for disparities in access, service, quality, safety, and health outcomes (Smedley et al., 2003). Second, the policies should encourage execution from the stakeholders, providers, government, industry, and community organizations to provide a comprehensive lens to address the multitude of factors

(Smedley et al., 2003). Diverse views contribute to intelligence on literacy in illiterate subgroups, enrollment of diverse patients in clinical research, and the tracking of best practices to the eradication of health disparities (Smedley et al., 2003). Third, contemporary research clarified the need for an improved racially and ethnically diverse workforce to improve the succession of minority health professions (Smedley et al., 2003). The training and development should be continuous and include the promotion of leadership development for minority health care providers (Smedley et al., 2003). Lastly, health care policies to address health disparities using pay for performance, must judiciously track and adjust for race, ethnicity, and socioeconomic status/factors to fairly apply measures and reward incentives for providers of care in underserved populations (Smedley et al., 2003).

Patient-Centered Care

Another healthcare strategy gaining prominence is patient-centered care (PCC). PCC is a measure of health quality in patient care with fundamental characteristics of patient participation in their care and the individuation of patient care (Robinson, Callister, Berry, & Dearing, 2008). Patient centeredness is a shift from Western medicine to Eastern philosophy in holistic health care. Robinson et al. (2008) stated that PCC includes a public policy, economic, clinical, and patient orientation. Patient-centered care is not a metric for clinician reimbursement, but has influence on medical education, credentialing, assessments of quality care policies, and licensure. Researchers revealed that PCC benefits communication, provider/patient relationships, and improvements in patient's adherence to treatment protocol (Robinson et al., 2008). In a survey sponsored by the National Healthcare Quality Report, Robinson et al. (2008) stated that PCC was used in 45%-62% on patient interaction. PCC was always or usually experienced in 89% of patient visits and never experienced in 6%-18% of patient visits. Interestingly, there was

a 12% variation among survey participants on age, race, education, income, perceived health status, and insurance coverage (Robinson et al., 2008). The challenge in overcoming the barriers to using PCC is the inability to define metrics for a patient-centered approach that does not decrease its scientific credibility. Adherence has risen as one factor in patient care to follow to increase the knowledge of PCC benefits in improving quality, patient satisfaction, and advancing research. The costs of non-adherence are estimated at $300 billion annually and the relationship between adherence and PCC can lead to health promotion and cost efficiencies (Robinson et al., 2008).

What may be missing from the PCC approach is the patient's perspective. Patient expectations are inclusive of values, needs, and wants. As consumers, they also value time, expense, and quality of care (Robinson et al., 2008). Researchers have identified characteristics as patient care, involvement in decisions, competency, availability/accessibility, courtesy, respect, and exploration of patient needs as priorities (Robinson et al., 2008). These priorities are no different than those requested by the general population.

Chronic Care Models

The incidence of chronic diseases in the U.S. is concerning. These diseases have an impact on both America and underdeveloped countries with recorded deaths of 58 million in 2008 (Davy et al., 2015). Sixty-three percent of these fatalities are attributed to chronic diseases related to cardiovascular, respiratory, diabetes, and cancer (Davy et al., 2015). Not only are these diseases pervasive in underdeveloped countries, the disenfranchised communities in developed countries, as in the U.S., carry an increased burden (Davy et al., 2015). Many of the diseases are believed to be addressed in the primary care setting to improve long-term health outcomes and

health practices (Davy et al., 2015). Primary health settings are described as the patient's primary contact by a single practitioner (Davy et al., 2015).

The primary contact provides continued care at the time needed, is accessible, and has a responsibility to provide coordinated care (Davy et al., 2015). The MacColl Institute for Healthcare Innovation at Seattle's Group Health was the first to develop a model for chronic care with interventions to address the growth in chronic disease (Davy et al., 2015). As a method to address the growth in chronic disease, researchers developed strategies with the objective to reduce fragmentation of disease management programs, while improving health outcomes (Davy et al., 2015). According to Davy et al. (2015), the MacColl Institute's care model was framed on these care elements:

- Mobilization of community tools and resources
- Promoting high level of quality care
- Enabling self-management of patients
- Implementing care aligned with evidence and patient preferences
- Effective use of population and patient data
- Cultural competence
- Coordination of care
- Health education and resources. (p. 3)

Researchers are still evaluating the best implementation and delivery of chronic care models to health care services. One or more of the elements can improve outcomes and also the relationship of the specific disease and heterogeneity of how the element is implemented can improve performance (Davy et al., 2015). With use of chronic care models, the integration of healthcare practice and health outcomes is critical as healthcare quality is a pivotal social

determinant of medical outcomes and savings to the costs of care (Davy et al., 2015). The researchers also noted the value of reflective practice to gain awareness of how medical care provided priorities and needs of neighborhoods served. Reflective practice is a guiding influence in acquiring knowledge and skills to bridge the divide in theory and practice and ultimately improve healthcare (Davy et al., 2015). Leaders have a key role in guiding the implementation and sustainability of chronic care models. Creating a positive work environment, providing clear direction, supporting reflective practice, and reducing the barriers of implementation of chronic care models stimulates the improvement in health outcomes and healthcare practice among populations (Davy et al., 2015).

Pay for Performance

Increased attention is now focused on incentivizing healthcare providers to reduce disparities in ethnic and racial populations by instituting pay for performance (P4P) incentives. Payers and policymakers reward quality of care to hospitals and clinicians who disproportionately care for minority patients (Weinick, Chien, Rosenthal, Bristol, & Salamon, 2010). P4P includes the objective of improving the cultural competence of providers. Racial and ethnic disparities are noted in areas where P4P initiatives in chronic diseases are common, such as diabetes and myocardial infarction (Weinick et al., 2010). Dissenters of P4P programs are concerned that providers may cherry pick their account and/or providers who participate to represent the healthiest among their populations (Weinick et al., 2010). According to Weinick et al. (2010), providers have excluded minority patients as they are perceived to lower the quality score. Furthermore, P4P safety net hospitals care for the majority of minority and poor patients and may be at higher financial risk, lacking the IT and management tools to perform well in P4P. Safety net hospitals also provide lower quality of care in all areas (Weinick et al., 2010).

Weinick et al. (2010) studied hospital executives who provided insight as they were the leaders responsible for the P4P programs. When asked if P4P incentives provided positive effect on racial disparities, some executives responded that P4P programs can lessen disparities and increase expectations in healthcare to benefit all (Weineck et al., 2010). Other health executives implied that P4P incited negative effects by rewarding affluent hospitals and medical groups that could afford to invest in infrastructure geared to measure positive outcomes on quality scores (Weineck et al., 2010).

A skewed reward for absolute measures could also widen disparities. An example is mammography rates: An institution with a large Caucasian population increased rates from 80%-90% while an institution with a large minority population increased mammography rates from 40%-70% (Weineck et al., 2010). This divergence in rewards could increase the health disparity in minority populations. Only 50% of health leaders reported that they were engaged in a P4P contract and 50% had targeted programs to reduce health disparities in ethnic/racial populations (Weineck et al., 2010). A small percent was collecting patient-reported ethnicity information associated to quality measures. None of the health executives had quality measures tied to a reduction in health disparities (Weineck et al., 2010).

Overall, healthcare executives and health leaders were uncertain if P4P measures were the correct method to address disparities in the U.S. There was skepticism if P4P addressed health quality and improvements in health expenditures. Most executives believed that P4P incentivizes more affluent non-safety net hospitals, thus diminishing resources and minimizing the ability to care for minority patients (Weinick et al., 2010). To increase the overall quality of care for minorities, hospital executives agreed that P4P program design and strategies should increase the awareness of disparities, reward features of care of importance to minorities,

improve access to care, and institute a separate incentive for safety net hospitals (Weinick et al., 2010).

Health strategies to support leaders and their role in developing and applying strategies to improving the healthcare system, patient care, and outcomes are most successful when approached in a systematic, multi-layered, and coordinated method. Support among stakeholders, patients, families, policymakers, providers, and community support structures can improve health delivery and the promotion of health equity policies can reduce the cultural, linguistic, and administrative barriers in health delivery. The adoption of comprehensive strategies, patient-centered care, P4P, health reform, and chronic care models all address the many causal contributors to health inefficiencies and disparities. Evidence supports the conclusion that several factors of health system-level interventions contribute to the improvement in quality of care for minority patients and narrow the health gap.

Leadership Development

As a $1.7 trillion-dollar industry, there is concern as to how healthcare organizations will meet the development needs of their leaders, as few have invested in leadership training. (McAlearney, 2006). As an industry, healthcare has not adopted best practices across industries it is plagued with medical errors, inequalities, and disparities in provision of care and treatment (McAlearney, 2006). As physicians have responsibility in the delivery of healthcare, the demands and norms expected of them call for continued training and development. Unfortunately, their developmental needs are not aligned to the organization as healthcare providers are typically individual owners and are outside of the purview and development pillars of health organizations (McAlearney, 2006). The competing stakeholders in healthcare, to include patients, families, insurers, and regulators, differ in their view on healthcare delivery and

contribute to the complexity of the effectiveness of the healthcare system (McAlearney, 2006). There is often a cultural divide between administrators and clinicians in steering the organization and coordination of healthcare that contributes to organizational chaos (McAlearney, 2006). Environmentally, regulatory influences of federal and state funded reimbursement programs leave the health providers powerless in influencing reimbursement rates or cost of care, while tasked to deliver a high quality of care (McAlearney, 2006). These competing priorities challenge health care leaders to manage financial and human capital while serving the needs of the community, patients, and internal and external stakeholders (McAlearney, 2006). It is noted that the impact of healthcare contributes to the wellbeing of the community and patients and that the actions of healthcare leaders correlate with organizational results (McAlearney, 2006).

The existing gap in health leadership calls for transformational leaders. Transformational leadership calls on leaders to be motivational, foster empowerment, inspire and communicate a vision, foster trust, follow values and norms, support change, and lead to achieve goals. The path to transformational leadership has yet to be realized in healthcare (McAlearney, 2006).

Applications in leadership development—defined as educational methods to improve skill and job performance—build leadership capabilities and impact the climate and culture of the organization (McAlearney, 2006). McAlearney (2006) interviewed healthcare leaders and identified six emergent themes reported to explain the challenges in leadership development:

- Theme 1: Industry lag—The healthcare industry is trailing behind other industries.
- Theme 2: Representativeness—Organizations should reflect the community and patient population.

- Theme 3: Professional conflicts—Need to differentiate professional groups from leadership development.
- Theme 4: Constraints on time—Challenge of freeing time for program participation.
- Theme 5: Technical obstacles—Organizational technical needs.
- Theme 6: Financial impediments—Budgeting, organizational demographic. (p. 973)

The challenges of healthcare leaders are boundless, but contrary to belief, the themes are like challenges across industries. The healthcare industry would benefit by benchmarking development programs that have transferable content and proven results, in addition to recruiting leaders with relevant experience to expedite the application and accelerate the development of leaders (McAlearney, 2006).

Health Policy

According to research by Dreachslin and Hobby (2008), ethnically and racially motivated disparities in health outcomes are produced by social variables outside of the control of any one organization. Organizational behavior can shape the policy towards health equity. In a report by the Institute for Health Policy (IHP), a multitude of health factors were identified that impact health policy. Areas for policy action include individual, societal, economic, structural, cultural, environmental, personal health management, and the delivery and funding of healthcare. The implication of health policy denotes the organization's intention and gives a roadmap of their action towards diversity (Dreachslin & Hobby, 2008).

Procedures should reflect written policy. An example is the use of interpreter services. Title 6 of the 1964 Civil Rights Act prohibited discrimination of individuals with diminished

English proficiency (Dreachslin & Hobby, 2008). Health systems that benefit from this policy and receive federal funding must provide patients face-to-face interpretive services.

Leaders of diversity set an objective for concordance in policy and procedure. Future steps guide leaders toward policies and procedures, plant/technology, and people (Dreachslin & Hobby, 2008). The policies developed with patient focus infer the health provider's interest is in delivering culturally relevant care. If the policy of waiting rooms is not the appropriate size to accommodate extended families or decorated rooms do not depict the ethnicity of the community treated, the policies will not ensure a positive experience for patients (Dreachslin & Hobby, 2008). Additionally, if technology is used to collect data on ethnicity and the results are not incorporated into planning or delivery, negative perceptions can ensue (Dreachslin & Hobby, 2008). A 2006 report by Health and Human Services concluded that racial concordance of matching demographics of employees and the community had direct benefits to improve public health (Dreachslin & Hobby, 2008). Improvements in increasing access to care for minority groups, matching diverse patients with ethnic health practitioners, sharing a similar language, and enhanced relationships and communication increased the opportunity for quality care (Dreachslin & Hobby, 2008).

Human resource policies and guidelines are vital to the framework of leadership diversity. Policies drive patient care, as well as the process for recruitment and retention of high caliber minority employees (Dreachslin & Hobby, 2008). According to Dreachslin and Hobby (2008), the components of human resource policies to address recruitment and retention include structured mentoring programs, training and development, work balance, affinity groups, and flexible benefits.

In 2003, the Commission to End Health Care Disparities was founded subsequent to a report by the Institute of Medicine (IOM; Smedley et al., 2003). The IOM report concluded the existence of health care disparities in therapeutic diseases, irrespective of patient access factors (Smedley et al., 2003).The commission represented medical and healthcare leaders and professionals from the National Hispanic Medical Association, American Medical Association, National Medical Association, and fifty additional health organization for the purpose of arriving at consensus and developing solutions and strategies to address health disparities (Smedley et al., 2003). The commission defined the drivers of health disparities as lack of health promotion and services, minimal financial and social resources in diverse communities, safety and urban design, and linguistic and cultural competency factors (Smedley et al., 2003). The IOM's goal was to develop healthcare disparities policy that ensured fair, relevant, effective, safe, and high-quality care for all, without gaps in services (Smedley et al., 2003). The goal was accompanied by implemented guidance that established a construct in the analysis, development, and implementation of policy. The critical principles to reduce health care disparities were:

- Relationship-centered: Patient, family, and community delivered care.
- Cultural and linguistic based: Tailored to requirements of diverse populations.
- Specifically, targeted: Address access, quality, medical care, and safety.
- Data-driven: Utilizing quantitative and qualitative data.
- Transparent, participatory, collaborative: Including input from all stakeholders.
- Address the long and short term-solutions: Developed to address the underlying causes and disparities, and to include structural and financial incentives to prevent recidivism.

- Comprehensive: Broad based and comprehensive to meet the social, cultural, political, and environmental factors.
- Judicious in the use of incentives and requirements: Include incentives and mandates.
- Fiscally responsible and bipartisan.
- Revise and evaluate: Monitor policies for intended and unintended results. (Smedley et al., 2003, p. 490)

The IOM Commission's important principles to form policy in ending health disparities served as a guideline for federal, state, local, and private organizational policy makers. The guideline's role in successful development and implementation of policy must also include the awareness and understanding of the vast contributing factors of socio-economics and determinants of health among population subgroups in the U.S.

Health Reform

The National Healthcare Disparities reports elucidated problems in healthcare access among minority groups (Kimbrough-Melton, 2013). From 2003 to 2008, 50% of the 250 health measures tracked indicated no improvement for racial groups in entry to care and 40% indicated the measures are worsening (Kimbrough-Melton, 2013). Structural barriers such as dearth of healthcare providers, transportation, and insurance coverage prevent access to care for minorities (Kimbrough-Melton, 2013). A prominent barrier in care is the lack of health insurance due to the lack of resources for minorities to purchase insurance (Kimbrough-Melton, 2013). According to the Kaiser Family Foundation, Hispanics are three times more likely than Caucasians to not have insurance. Compared to 13% of Caucasian Americans, 27% of Native Indians, 21% of African Americans, and 18% of Asian Americans have health insurance (Kimbrough-Melton, 2013).

Compared to Caucasians, 70% of African Americans, 79% of Latinos, and 70% of American Indians are in low wage, blue collar employment and lack employer-funded health insurance. The advent of Medicaid has narrowed the gap in access for children and adults, but minorities represent the largest segment of uninsured (Kimbrough-Melton, 2013).

The Affordable Care Act (ACA) is the most important law in health care in the U.S. since the creation of the 1965 introduction of Medicare and Medicaid (Obama, 2016). The law enacted comprehensive reforms to enhance access, affordability, and the quality of healthcare (Obama, 2016). The law was written to expand covered to the uninsured and to contain the exorbitant costs of healthcare (Orszag, 2016). The approach of the ACA was to also increase the numbers of U.S. citizens who have private insurance or can benefit from the government assistance subsidized programs referred to as Medicaid, the Children's Health Insurance Program (CHIP), and Medicare (Kimbrough-Melton, 2013).

Enrollment target of the ACA was to expand insurance to 26 million Americans by 2024 (Adepoju et al., 2015). In the first year of enrollment, eight million citizens bought the private federal and state plans and 6.7 million enrolled in Medicaid's public funded plan for low income people (Adepoju et al., 2015). With the ACA's expansion of Medicaid to the states and District of Columbia, only 27 states in the nation and the District of Columbia elected to expand Medicaid (Adepoju et al., 2015). The states that declined expansion left four million Americans without health coverage, with these states having the highest poverty and uninsured rates in the nation (Adepoju et al., 2015). This gap in Medicaid access inhibited progress toward improving insurance disparities among the minority groups as the remainder of Americans moved toward health reform (Adepoju et al., 2015). The ACA was created to expand access to healthcare for millions of Americans. The ACA provided access to care to millions of people of color without

quality and affordable healthcare (Kimbrough-Melton, 2013). It was estimated twenty million Americans gained insurance coverage as a result of the ACA, a reduction in healthcare costs, and improvement in quality (Orszag, 2016). The amount of uninsured was at its lowest level in half a decade and access to health care improved for millions of Americans (Jost, 2015). In addition, the costly burden of hospitals caring for the uninsured declined in response to the expansion of Medicaid (Jost, 2015).

According to the Robert Wood Johnson Foundation, the national health costs declined 11% from $2.6 trillion during the period of 2014 through 2019 (Orszag, 2016). The improvements in the healthcare system are not representative of health outcomes but indicate improvement in the measures for success in the process of care (Bauchner, 2016). Improvement in readmission rates declined and access to healthcare improved (Bauchner, 2016). Bauchner (2016) reported that the timeframe to show improvement in a population takes years, as well as to influence the health of an individual.

Consideration for the public factors or social determinants of health contributes more to the population's outcomes than does healthcare (Bauchner, 2016). The ACA recognized that social determinants and cultural competence were the most critical determinants of health. As part of the emphasis to increase diversity in healthcare, the ACA expanded primary care with a focus on the physician's attention to social determinants via community-based programs (Kimbrough-Melton, 2013). The programs were designed to link patients with community resources and infrastructure. Neighborhood programs to assist the healthy lifestyles, restaurants, schools, and places of employment were strategies to contribute to the elimination of disparities (Kimbrough-Melton, 2013). To encourage participation, ACA increased Medicaid reimbursement to the physicians who participated (Kimbrough-Melton, 2013).

Challenges to the U. S. health care system remain an obstacle. Inequality, inefficiency, expense, and public awareness are concerns noted (Kimbrough-Melton, 2013). Inequality in reducing health disparities in ethnic and racial populations is a primary focus of the ACA and the causes that have contributed to the bias in disparities of this population will take time to correct (Kimbrough-Melton, 2013). The second challenge is how inefficiency and vast administrative costs have enlarged the disparate impact on minority groups in affordability of care. Even when insured, minority groups can only afford the lower tier plans with limited benefits (Kimbrough-Melton, 2013). Third, the U.S. system is plagued with exorbitant costs, copays, and deductibles for preventive services, wellness screenings, and cancer tests (Kimbrough-Melton, 2013). Lastly, ill-informed Americans are naïve about the law and how was implemented. The ignorance of the ACA was 57% among racial and ethnic groups. For the public who were aware, only half confirmed they lacked information about how their family would be impacted (Kimbrough-Melton, 2013).

The ACA included language to improve the health system for minorities. In order to identify and reduce health disparities, provisions were instituted to improve the collection and reporting of data to assist the federal government in deciphering the context of disparities and strategies to employ (Kimbrough-Melton, 2013). To improve healthcare's diverse workforce, the ACA provided funding to various institutions, including the nation's historically African American universities to expand their diversity in the health professions for primary care, long term care, mental health, and dentistry (Kimbrough-Melton, 2013).

Health strategies to support leaders and their role in developing and applying strategies to improving the healthcare system, patient care, and outcomes were most successful when approached in a systematic, multi-layered, and coordinated method. Support among stakeholders,

patients, families, policymakers, providers, and community support structures can improve health delivery; while promotion of health equity policies can reduce the cultural, linguistic, and administrative barriers in health delivery. The adoption of comprehensive strategies, patient-centered care, P4P, health reform, chronic care models, and health reform all address the myriad causal contributors to health inefficiencies and disparities. Evidence supports the conclusion that several factors of health system-level interventions contribute to the improvement in quality of care for minority patients and narrow the health gap.

Chapter 3: Research Design and Methodology

Introduction

This study intended to identify health care disparities and to associate strategies employed by healthcare leaders to improve healthcare outcomes for patients in the U.S. Understanding the strategies implemented for improved health outcomes for leaders will contribute to the study of health outcomes and the causal contributors of disparities, leadership, cultural competency, health reform, and social determinants. Interpreting participants' insights and strategies was achieved by the process of qualitative research. The qualitative methodology applied was phenomenology and the qualitative research was executed by participant interviews. Chapter 3 details the qualitative research methodology design, the phenomenological approach, and the explanation of why this was the optimal design for this research. The sampling methodology, participant response, and unit samples are defined. The considerations for the human participants that ensured safety, privacy, and oversight are included. The validity and reliability of techniques and potential biases of the study are addressed. The data collection process and interview protocol are described in detail. The ultimate research findings and methodological summary are provided within.

Given that the U.S. outspends all nations in healthcare delivery but has the worst outcomes and that treatment outcomes do not come close to matching levels expected for those expenditures, this research was intended to contribute to the repertoire of existing research and propose strategies for immediate planning, implementation and future recourse. There are data to support the theory that disparate results in care are a result of the inequities of the healthcare system. The focus area for this paper explored the existing state of healthcare, causes of disparities, and health care policy. An evaluation of leadership strategies identified the role

leaders have in supporting the healthcare needs of many with respect to cost, access, affordability, and outcomes. The current system and market favors those who have financial means to pay for better coverage while the staggering costs for middle and working classes and small business owners confront limited resources and options for healthcare. Leaders of health organizations are under demand to practice with competency and generate acceptable patient outcomes with affordability and attention to quality (Saeed et al., 2015). Although care teams are tasked as a group to deliver patient care, it is usually the responsibility of the physician to make changes to impact clinical outcomes (Saeed et al., 2015). Considering the research, few gains have been realized from healthcare leaders to improve the delivery of care, quality, and health outcomes.

Restatement of Research Questions

This study employed a qualitative approach to address the following research questions:

RQ1: What are the challenges you face regarding influencing healthcare outcomes?

RQ2: What current strategies do you use to address these challenges and barriers?

RQ3: How do you measure and track your success with overcoming challenges and barriers?

RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?

Nature of the Study

The purpose of this research was to identify the disparities, using a phenomenological approach to explore the impact on diverse populations and provide insight on the strategies to improve health outcomes. The research focused on the areas of identifying leadership challenges in treatment, disparities, and measures of success. In addition, the research identified types of

disparities confronting healthcare leaders and employed a phenomenological approach to explore the impact to diverse populations and provide insight on the models to impact change. When researchers are attempting to reveal what is occurring and searching theoretical frameworks, theory is used incorporating inductive thinking (Boeije, 2010). Boeije (2010) stated the intent of qualitative research was to chronicle and understand a social phenomenon to assign meaning. The questions researched were studied with flexible methodology to enable connection with the participants to understand what was happening in the natural environment.

Qualitative research offers assumptions that individuals, who are given an active role in the genesis of social experiences and research methods that catalogue the process, are an essential requirement (Creswell, 2014). Qualitative researchers agreed that the constructivism and interpretivism in assumptions add a level of diversity to the practice of qualitative research (Boeije, 2010). A qualitative research approach was chosen as the most suitable methodology for this study based on the use of qualitative research questions to interpret a participant's experiences**.** The intent was to describe the strategies that health care leaders implement to eliminate health disparities and deliver positive health outcomes. This approach was efficient as it focused on similar strategies and disparities in achieving healthcare outcomes by leaders.

Chapter 3 provides a description of the research methodology, research design, instrumentations, and the data collection process. The study was proposed because the researcher was interested in gaining a clearer understanding of the contributing factors to how a greater representation of healthcare leaders could help address the needs of a diverse populace by improving cultural competence, outcomes, access, and policy. As healthcare leaders can directly impact the patient, their experiences, and treatment outcomes, the qualitative route of inquiry into the human experience was implemented.

Strengths

The strengths of qualitative research provide investigators the options to study their participants; study the processes, events, and activities; and/or research culture sharing behavior among individuals or larger groups (Creswell, 2014). Polkinghorne (2005) described qualitative research as a method of inquiry with an objective to clarify the subject's real-life experience. Unlike other events in nature that may be rigidly and mathematical based, the human experience may pose several layers and facets of exploration. Research approaches best used for physical items are not the optimal measure of a human experience (Polkinghorne, 2005). Based on the interpretation of a participant's experience and best practices of a qualitative research design that details and brings awareness, it was agreed that a phenomenological approach was the best design for this study (Polkinghorne, 2005). According to Creswell (2014), qualitative methods educate readers on the intent, design, role of researcher, analysis of information, date recording, validity, and reporting on outcomes.

Weaknesses

There are inherent weaknesses in the use of qualitative methodology. In contrast to the benefits of qualitative inquiry, researchers accept that their data are not observable and rely on the participant's skill in reflection and discernment of experiences (Polkinghorne, 2005). The inability to witness firsthand experience causes the researcher to rely on the participant to accurately reflect and interpret human behavior (Polkinghorne, 2005). There is also concern about the validity of the qualitative instrument used. Polkinghorne (2005) raised doubts regarding a participant's limited access to the language and numeric translation and access to their thoughts. The partial access to an experience may distance the evidence of the captured experience to the actual experience itself. Maxwell (2013) concurred that qualitative research

must address the plausible threat to validity to a proposed explanation. Qualitative research offers assumptions that individuals are given an active role in the genesis of social experiences and research methods that catalogue the process are an essential requirement (Creswell, 2014). Qualitative researchers agreed that the constructivism and interpretivism in assumptions adds a level of diversity to the practice of qualitative research (Boeije, 2010).

Methodology

There are many methods used by researchers to conduct research. Research systematically collects, analyzes, and interprets data to increase awareness and learning of phenomenon of interest. Phenomenological research, as described by Creswell (2014), is a structure of inquiry borne from psychology and philosophical sciences to describe a participant's experiences about a phenomenon.

According to Maxwell (2013), in a qualitative research design, the process should be reflexive at each stage of a project**.** Experiences have a vertical depth that is not suited for briefly answered surveys or scales. Scales and surveys only capture surface information. The data obtained for experiential studies should contain a participant's self or first-person reporting of personal experiences. The phenomenological captures the essence and depth of experiences (Polkinghorne, 2005). Phenomenologists work with more than specific reporting; they find commonalities in statements and experiences (Creswell, Hanson, Clark, & Morales, 2007). Moustakas (1998) described methodology as the construct which research is executed for increased knowledge, comprehension, and truth. In the concept of this research, the concept to be studied is the phenomenon of leadership strategies to impact health outcomes.

Structured Process of Phenomenology

A phenomenological qualitative methodology was applied to this study and research was conducted via semi-structured interviews. Phenomenological research is a design of inquiry related to psychology and philosophy where researchers detail the personal history and lived experiences of participants (Creswell, 2014). The researcher gathered data and created a composite description summarizing the collective experience (Creswell et al., 2007). The data were then codified into coded words or themes into structural or textual statements to provide a summary of the data collected by participants (Creswell et al., 2007). The process of inquiry concluded with the theme of the phenomenon experienced by many of the participants (Creswell, 2014). Creswell et al. (2007) described the structured process as follows:

- Identification of the participants to be interviewed about the phenomenon.
- Describe the essence of the study.
- Determine number of participants to interview. Polkinghorne (1989) recommended interviews should include 5-25 individuals.
- Schedule best times to interview participants and the mode/instrument of inquiry.
- Analyze experiences with significance on meaning and broader themes.
- Summarize experiences and themes and reflect on the correlation to literature reviewed.

Phenomenologists describe the commonalities of the participants as they experience or have experienced a phenomenon (Creswell et al., 2007). Phenomenological research encompasses the analysis of critical statements, meaning of units, and the essence of description (Moustakas, 1998). Also important to this process was that the research was derived from the participant's interpretation and not the researcher's interpretation (Creswell et al., 2007).

Appropriateness of Phenomenology Methodology

A qualitative research approach was chosen as the most suitable methodology for this study based on the use of qualitative research questions**.** The study was conducted due to the researcher's interest in gaining a clearer understanding of the contributing factors on how a greater representation of healthcare leaders would help to address many of the needs of a diverse populace. The focus was on improving cultural competence, outcomes, access, and policy. The phenomenological data analysis process was consistent with the approach described by Creswell et al. (2007). In phenomenology theory, views are collected from many participants. This design was selected as an appropriate method to learn about the experience being investigated by the participants. The study was conducted using semi structured interviews. Purposeful selection of the participants was used to help understand the problem posed in the research questions. After the data were gathered, data analysis was conducted using an analysis technique. Ethical standards were maintained, and IRB approval was obtained prior to the beginning of the study (see Appendix A).

Research Design

This design was selected as an appropriate method to learn about the experience being investigated by the participants. The study was conducted using semi structured interviews to gather the data posed in the research questions.

Analysis Unit

This study sought to identify leadership traits of a unit of analysis, which for this study was a healthcare leader in the U.S. To fulfill identification of this role, the following characteristics that comprised the unit of analysis were identified:

- Be a male or female healthcare leader;

- Be currently employed full-time in the current leadership or patient-facing leadership position;
- Have served in a healthcare leadership role for at least two years; and
- Served in a role of healthcare leader, executive, medical director, medical provider, health system leader, CEO, vice president, or president.

Population

The pivotal point of qualitative research is to assert claims about a population from the sample of that population researched (Polkinghorne, 2005). In qualitative research, the size of populations can vary from cultures and subcultures within a larger society, to special populations who are studied due to their beliefs, behavior, or relevance to the group (Trotter, 2012). Qualitative sampling addresses much of validity issues of a small population, but has trouble with generalizations to large populations (Trotter, 2012). The generalizations on multimodal and diverse populations in processes, values, beliefs, and knowledge carry epistemological challenges (Trotter, 2012). Thus, statistical research relies on representative or random selection of data sources from that population (Polkinghorne, 2005). The population for this research consisted of healthcare leaders who had been in a leadership role for at least two years and appeared in the HealthCare Inc. list of top CEOs.

Sample Size

The cornerstone of research integrity is sampling in all disciplines of social sciences (Abrams, 2010). Sampling decisions in qualitative research weigh on the degree of credibility of the findings and on the scope of the research's application to real life issues (Abrams, 2010). According Trotter (2012), among researchers there are inconsistencies in determining sampling frameworks and sample sizes in qualitative research. Some researchers determined sample size

by conducting an analysis of a theoretical framework, characteristics, and statistical analysis. Researchers who chose to sample purposively believed that some participants may be more situated to share their insights and experiences than those who were randomly sampled. Phenomenological research involves smaller samples of specifically selected participants who share similar experiences, with an objective of eliciting general patterns in meaning and relationships (Abrams, 2010). Most researchers favor sampling designs with 15 to 25 experts (Trotter, 2012). Sample choices in qualitative research are more prone to the researcher using a nonrandom, small, and purposeful selection (Merriam, 2009). Purposive sampling of 15 U.S. healthcare leaders were selected as research participants from a defined population, based on the theoretical framework that guided the study. The 15 American leaders were healthcare leaders with enough experience to share their insights on healthcare challenges and recommended strategies.

Purposive Sampling

The intent of research was to make assertions of a population on the basis of the representative sample (Polkinghorne, 2005). According to Boeije (2010), a sample is a unit or cases defined from a population to participate in research. Polkinghorne (2005) stated that purposive selection of data sources relies on the selection of people or documents that the researcher can gain information and insight from the experiences. For this research, purposive selection of the participants allowed the researcher to bring valid and rich data in order to learn about the central issues of importance to the research. As the study concentrated on health care leaders, the researcher was interested in leaders who had direct influence on health policy, administration, patient care, health education, health systems, and health institutions with at least two years in their respective role. Participants were purposively recruited if they fit the criteria of

being a healthcare leader in the U.S. Healthcare leaders included the roles of CEO, hospital executive, medical director, president, vice-president, healthcare provider, health plan director, or chief medical officer. Participants were non-randomly selected in a quasi-experiment. A quasi-experimental research design is common, allowing the researcher to address questions about the relationship between variables and if differences exist among variables (Butin, 2010). From this population, 15 participants receive invitations to participate in the study interviews.

Participation Selection: Sampling Frame to Create the Master List

This study sought to identify leadership traits of a unit of analysis, which for this study was a healthcare leader in the U.S. To fulfill identification of this role, the following characteristics that comprised the unit of analysis were identified:

- Be a male or female healthcare leader;
- Be currently employed as a full-time in the current leadership or patient-facing leadership position;
- Had served in a healthcare leader role for at least two years; and
- Served in a role of healthcare leader, executive, medical director, medical provider, health system leader, CEO, vice president, or president.

The sample population includes individuals who met the inclusion criteria and were invited to participate in the research. The inclusion criteria set specific characteristics for selection of the 15 participants. Using a multi-stage clustering procedure, the researcher identified the first source as the Healthcare Inc. organization and then following the first stage, obtained the names of healthcare leaders within the groups, and then selected samples from the cluster. Participants who had at least two years of experience as a healthcare leader in the Healthcare Inc. list of top CEOs were selected from the continental U.S.

Participants were purposively recruited if they fit the criteria of being a healthcare leader in the U.S. Healthcare leaders included the roles of CEO, hospital executive, medical director, president, vice-president, healthcare provider, health plan director, or chief medical officer. Participants were non-randomly selected in a quasi-experiment. Population of the participants in the Healthcare Inc. Top CEOs list was the first inclusion criteria to be a participant in the study. Of the 5,000 executives on the list, further exclusion and inclusion criteria were needed to create the participant sample. Further segmentation narrowed the population to additional inclusion criteria of health-related roles. The inclusion of criteria for roles of CEO, hospital executive, medical director, president, vice-president, healthcare provider, health plan director, or chief medical officer specified the population to an executive level position. Additional inclusion criteria were that the participant must have at least two years in his or her current role and be geographically based in the contiguous U.S. Participants were excluded from the research if they did not fit the inclusion criteria. Detailed information on selected participants from company websites, social media, articles, and books was used to validate the variation of the purposive sample group.

Inclusion Criteria

The robust process of selection identified individuals who met the inclusion criteria for the study while providing information-rich cases. Subjects who were ultimately chosen for the study and asked to participate were also asked to verify inclusion criteria prior to participation. The inclusion criteria set specific characteristics for selection of the 15 participants:

- Population of the participants in the Healthcare Inc. Top 5000 Executives list was the first inclusion criteria to be a participant in the study. Of the 5000 executives on the list, further exclusion and inclusion criteria was needed to create the

participant sample. Further segmentation narrowed the population to additional inclusion criteria of health-related roles.

- The inclusion of criteria for roles of CEO, hospital executive, medical director, president, vice-president, healthcare provider, health plan director, or chief medical officer specified the population to an executive level position.
- Additional inclusion criterion was that the participant must have had at least two years in his or her current role, and be geographically based in the contiguous U.S.

Exclusion Criteria

The exclusion criteria for this study included:

- Declining to sign or verbally acknowledge the informed consent;
- Declining to acknowledge verbally that he or she meets all inclusion criteria;
- Business focus was not related to patient care in a healthcare setting; or
- Having less than two years of healthcare leadership experience.

Maximum Variation

This research incorporated the form of purposive sampling known as maximum variation. The researcher portrayed the heterogeneity of the population sample by depicting the diverse characteristics of the sample. This is referred to as maximum variation sampling (Maxwell, 2013). According to Maxwell (2013), the goal of maximum variation sampling is to verify that the findings will portray the depth of diversity of experience and not only a typical conclusion of the subset. Maxwell (2013) described the process as first defining the dimensions of diversity of characteristics relevant to the research and follows with a systematic selection of the participants who represent the dimensions for criteria. The criteria of selection in maximum variation in this

study included field of research, role, geography, location, and tenure. These factors were derived from the literature review as having applicability and experience relating to the research objective.

Protection of Human Subjects

Participants were selected by meeting a four-point characterization criterion, and then via purposive sampling within that subpopulation. After the data were gathered, data analysis was conducted using an analysis technique. Ethical standards were maintained, and IRB approval was obtained prior to the beginning of the study. Adherence to human subject considerations was considered pursuant to standards established by Pepperdine University and the Institutional Review Board (IRB). To minimize risk and protect the identity of participants, pseudonyms and identifier codes were used for reporting the results. Interviews were audio recorded using a Dictaphone and recording feature on the iPhone, regardless of whether video conferencing was used. The interviews were conducted via Skype; however, the Skype sessions were not recorded.

All recorded (written and audio) information given by participants was stored in secured locations. Interviews were recorded using a password protected electronic recording device and the audio files were transferred to the researcher's laptop. Participants' names were not associated with the recording and pseudonyms were applied in the file names. Measures to protect the confidentiality and privacy of the participants were applied when reporting the data collected through not conveying the participants' names, recognizable information, and/or the organization they were associated with. Participants who agreed to participate in the research study were provided an informed consent form, along with the information related to (a) the purpose of the study, (b) Pepperdine University's IRB protocol, and (c) a copy of the interview questions. Confidentiality of participants was maintained during the research process. To minimize risk and

protect the identity of participants, pseudonyms and identifier codes were used when reporting the results. The identities of the human subjects were known only to the researcher. To minimize risk to participants, they were assigned a unique number and code, accessible only to the researcher, and personal identifiers were removed to protect confidentiality. There was no identifiable data. Data obtained through a recording device were deleted after transcription.

The interviews may also have been conducted via Skype; however, the Skype sessions were not recorded. The researcher took notes during the sessions. The protocol for the unique code was a four-digit number that represented the month and day of the interview. If two or more interviews occurred on the same day, a letter was added following the four-digit code. For example, the first interview was assigned 1101A, the second 1101B, et cetera. The key to the code and a participant's personal descriptive information were kept in a safe location and physical safe only known and accessible to the researcher for adherence to ethical considerations. In addition, printed and electronically recorded data were secured to protect participant confidentiality, as well as research integrity. Skype addresses of participants were removed from the researcher's contact list. The information collected and analyzed (e.g. recorded interviews, transcriptions, notes, and coding sheet) were only available to the researcher and secured on a USB drive. Responses obtained through the participant interview and the association of the respondent remained confidential. According to Pepperdine University IRB policy, all research related confidential documents are to be destroyed three years after the conclusion of this research study.

As mandated by Pepperdine University, the researcher generated and filed a dissertation exempt application before recruiting subjects and beginning research. In accordance with Pepperdine University's policies, as EDOL students, there was strict adherence to the three

principles prescribed by the Belmont Report. Those three tenets are: respect for the individual, beneficence in which the researcher makes it their priority to have the participant's welfare a goal of the trial, and those actions that extend kindness, justice, and charity. As this research was initiated, the investigator was thoroughly compliant with the Pepperdine University Institutional Review Board rules regarding protection of participants, creation of trust, and refrained from negligence, unethical behavior, or impropriety that could negatively reflect on the research, the participant, or their organization. The IRB, in addition to the U.S. Code of Federal Regulation, also required additional stipulations. Those requirements were to ensure all risks to participants were minimal and reasonable, in the scope and relationship to the predicted research benefits. Second, the study process utilized validated research design structure without risk to participants. Lastly, the choice of participants followed unprejudiced and objective measures for the intent of the research.

Informed Consent

Informed consent was obtained and documented to verify each participant's awareness and understanding of the risks and benefits of the study so he or she could elect whether to participate (Boeije, 2010). Research commenced with granted permission and participants were invited to participate. A consent authorization detailing the purpose and nature of the study, an explanation of risks, and guidelines for confidentiality were given to each participant. The consent form also educated participants of their right to withdraw at any time without prejudice during the research. The research design incorporated data monitoring measures to guard the safety of the participants. Informed consent additionally included safeguards for participants' privacy, assurance of confidentiality, and protection from duress or unwarranted pressure (see Appendix B).

Participant Confidentiality

Each participant was assigned a unique number and code, accessible only to the researcher, and personal identifiers were removed to protect confidentiality. Data obtained through a recording device were deleted after transcription. The protocol for the unique code was a four-digit number that represented the month and day of the interview. If more than one interview occurred for the day, a letter was added following the four-digit code. For example, the first interview was assigned 1101A, the second 1101B, et cetera. The key to the code and participant's personal descriptive information was kept in a safe location and physical safe only known and accessible to the researcher for adherence to ethical considerations. In addition, printed and electronically recorded data were secured to protect participant confidentiality, as well as research integrity. Responses obtained through the participant interview and the association of the respondent remained confidential. According to Pepperdine University IRB policy, all research related confidential documents are to be destroyed three years after the conclusion of this research study.

Data Collection

In qualitative research, there are several means to collect data. Among the ways in which researchers collect data are via verbal sources, correspondence, multimedia, photos, videos, and observation (Boeije, 2010). Most important is that the data collected by researchers provide evidence to findings, explanation, interpretation, and descriptions (Boeije, 2010).

The most prevalent approach to the collection of qualitative data is personal interviews with research participants (Polkinghorne, 2005). This research study of healthcare executives employed one-on-one semi-structured interviews, including open-ended questions for data collection. The participants were invited via e-mails and telephone calls. Participants were

provided an informed consent form at the time of the interview. During the semi-structured interview process, the researcher delivered open-ended questions to guide the interviews and if necessary, added spontaneous probing and follow-up questions for clarity or to gain deeper insight. The time of interviews was scheduled from 45 to 60 minutes and each interview was recorded by Dictaphone and iPhone, transcribed, and coded.

Interview Techniques

Interviews are the preferred research method in the social sciences for collecting valuable data in a controlled and effective practice (Butin, 2010). In contrast to surveys, interviews are in person and allow the researcher to hear context, see body language and expressions, ask follow-up questions, and offer a personal approach (Butin, 2010). When conducting interviews for qualitative research, the researcher serves as the instrument. Through a reciprocal relationship based on rapport, the researcher learns about the experiences and perspectives of the participants (Boeije, 2010). The rapport building is a skill of active listening, focus on the participant's experience, and getting them to respond orally, while detailing an accurate account (Polkinghorne, 2005). The participant one-on-one interviews elicited observations on their individual challenges and strategies and an understanding of the needs of the healthcare industry. The course of investigator initiated and sustainment of multi-sided relationships with humans in a natural environment to develop scientific comprehension is participant observation (Boeije, 2010). Participant observation is a combination of cultural anthropology and sociology research strategy that occurs in everyday life rather than a laboratory (Boeije, 2010).

This study employed semi-structured interviews during a one-on-one interviewing process. Qualitative interviews allow researchers to learn about social life through the perspective of the participant's experience, language, and culture (Boeije, 2010).

Phenomenologists group the experiences from a participant's statements into commonalities or themes (Creswell et al., 2007). A pre-designed interview guide was used to conduct the semi-structured interviews (see Table 2). Given that this study was exploratory and qualitative in nature; open-ended questions were used to elicit participant's insights, feelings, beliefs, and practices about leadership in healthcare.

Interview Protocol

Creswell (2014) recommended that researchers develop and use a protocol when recording field observations and plan their approach. The plan should detail the approach to the recording of data, what data were recorded, and the instruments used. The interview protocol suggested by Creswell (2014) included:

- Notes or audio should have a heading with the date, location, and names of participants.
- Instructions to follow for standardization for each interview.
- Begin with ice-breaker followed by selected questions.
- Follow up probing questions.
- Time between questions to record responses.
- Acknowledgement of commitment and thank you statement to participant.
- A log or record of data collected.

The following is a summation of the final research interview protocol. The protocol was reviewed by the Pepperdine preliminary review committee and approved by the Pepperdine dissertation committee. Because the protocol was designed for a specific one-time use, traditional methods of establishing reliability of a data collection instrument were not applicable. Data were collected from participants over a 4-week period utilizing the qualitative methodology

conducted via interviews. The data-gathering instrument was a set of 10 open-ended interview questions (see Table 4) that helped answer the four research questions. As few data were available on the research topic, the data collection instrument was created independently by the researcher. Developing a new instrument was important because the questions that needed to be addressed in the data gathering process were specific to authentic health care leaders. The responses gathered helped to identify leadership strategies to improve healthcare outcomes. Table 1 shows the relationship of the variable to the data sources from which the variable would be studied. It lists the group of healthcare leaders who would participate by completing the quantitative survey.

Table 1

Relationships Among the Variable, Data Sources, and Respondents

Variable	Data Source	Participants
Current healthcare leaders	Eleven qualitative, open-ended interview questions	Leaders in the healthcare industry

The interview protocol was developed and refined based upon feedback from a preliminary review panel and the dissertation committee. Data collection focused on the leadership effectiveness of authentic senior leaders at healthcare companies. These data were used to determine best practices and challenges in leadership and offer advice for future leaders. The data source that was utilized to conduct this research was based on a single variable. For this research, interviews were conducted face-to-face, or through video conference as needed and as a contingency approach. The participants in the study came from various locations in the U.S. Healthcare leaders who agreed to participate were selected from the list of Healthcare Inc.'s top

5,000 CEOs to participate as human subjects. Site permission was also secured for locations where interviews were held. After receiving approvals from each participant, site leaders, and Pepperdine's IRB, the targeted human subjects received an invitation (see Appendix C) explaining the study and inviting them to be part of it. During this initial contact of the final list members, the approved IRB recruitment script was followed.

A core, common, and consistent methodology was applied for each interview as part of this study. The interviews began with general greetings and gratitude for the participant's time. Next, the specific interview protocol was reviewed, which included the selection criteria for participation in the study, an overview of the interview topic, an overview of how the actual interview would be conducted, and what would happen once the data were collected. It was also explained to the participants that the interview protocol was formulated by the researcher and reviewed by a preliminary review committee and the dissertation committee. Participants were briefed on the informed consent, which was also distributed prior to the interview.

Interview Questions

Before each interview began, all participants received an overview of the mechanics of a qualitative, phenomenological study, executed as a semi-structured interview. Next, each participant was asked if he or she would permit the interview to be audio recorded. Once permission was obtained, the interview began. For some of the interviews, additional prompting questions were required to get to the essence of the interview questions. Some examples of the additional probing included phrases such as: "Can you be more specific or can you tell me more?" Consistent with most semi-structured interviews, specific follow-up questions were asked to expand upon responses or get more detail. Once the 11 questions were asked and answered, a request was made for the participant to make himself or herself available should

there be a need for future clarification or follow-up questions. The participants were also offered a copy of their recorded transcript to ensure accuracy. Each interview ended with an expression of appreciation for the participant's time and energy, and a reinforced commitment to share the results of the study once completed.

Relationship Between Research and Interview Questions

This study employed semi-structured interviews during a one-on-one interviewing process. The following open-ended questions in relationship to the research questions were used to elicit participant's insights, feelings, beliefs, and practices about leadership in healthcare.

Table 2

Relationships Between Research Questions and Interview Questions

Research Questions	Corresponding Interview Questions
RQ1: What are the challenges you face regarding influencing healthcare outcomes?	IQ 1: Tell me about your career? IQ 2: What are the cultural challenges you face regarding influencing healthcare outcomes? IQ 3: What cultural barriers do you face with diverse communities?
RQ 2: What strategies do you use to address these challenges and barriers?	IQ 4: What strategies do you use to address cultural challenges and barriers? IQ 5: What strategies do you use to address diverse communities?
RQ3: How do you measure and track your success with overcoming challenges and barriers?	IQ 6: How do you measure and track success with cultural barriers in achieving health outcomes? IQ 7: How do you measure and track your success with diverse communities? IQ 8: How do you measure and track success in other areas? (continued)
RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?	IQ 9: What mistakes have you learned from and what lessons have you learned? IQ10: What lessons would you share with emerging healthcare leaders? IQ 11: What recommendations would you make to improve outcomes?

Reliability and Validity of the Study

It was the position of the researcher to conduct a sound, unbiased study. An essential element of credible research is the assurance that the instrument in the interview protocol is both valid and reliable. Two critical indicators for research quality are reliability and validity. Validity is related to the accuracy of a data set. Validity also refers to the correct use of measures and being prescriptive in establishing what the research is powered to do (Boeije, 2010). Both elements are discussed in detail here.

Validity is a benefit of qualitative research in determining if the research findings are an accurate account from the participant or researcher (Creswell, 2014). Reliability is the consistency in which the data would be collected should the experiment be replicated. It is often determined by calculating internal consistency and stability of data over a time period by testing and retesting with an assumption that the measure will garner the same outcome (Boeije, 2010). For this research, to achieve reliability, participants were asked the same survey questions with the same instrument. Consistency in administration and selection of participants ensured reliability. To achieve reliability, participants were asked the same survey questions with the same instrument. Consistency in administration and selection of participants ensured reliability.

There are eight strategies employed to verify the accuracy of data collection. Creswell (2014) recommended using more than one approach to convince the reader of its trustworthiness, authenticity, and credibility. The following strategies were cited by Creswell (2014):

- Triangulating data sources.
- Using member checks in verifying data with participants.
- Conveying findings with robust descriptions.
- Clarifying potential bias researchers may bring to the study.

- Being transparent in presenting negative or discrepant data that present contrary themes.
- Spending an abundance of time in the field.
- Strengthening account accuracy with the use of peer briefing.
- Having the study reviewed by an external auditor (pp. 201-202).

Prima-facie validity. Prima facie is a legal term that broadly translated means *at first sight*. The first step of establishing instrument validity is prima facie validity. The interview questions were designed from data in the literature review and the examination of similar qualitative studies. The dissertation committee shared many interview questions with the researcher's cohort of doctoral candidates as examples of reliable and valid questions. Using these research questions as a foundation, the questions for this study were drafted to be aligned and consistent in terms of question content and structure.

Peer-review validity. Creswell (2014) recommended peer debriefing to strengthen the exactness of an account. With this strategy, adding another interpreter outside of the researcher adds validity to an account. To add peer validity to this research, a group of Pepperdine University doctoral students with significant business experience were asked to serve as peer reviewers (see Appendix D). This group included four students, and two had over 25 years of human resources experience in large, global companies. The peer reviewers were similarly conducting comparable research methodology in their own study areas. After a thorough review and discussion of research questions connected to this study, the peer group provided edits, questions, comments, and revisions to the interview questions (see Table 3 and Table 5).

Table 3

Peer Review Validity

Research Questions	Corresponding Interview Questions
RQ2: What are the current strategies and practices are employed by healthcare leaders to influence healthcare outcomes?	6: What strategies do you use to incorporate your strengths in your leadership role that influence health outcomes a. The question is directly relevant to Research question - Keep as stated b. The question is irrelevant to research question – Delete it c. The question should be modified as suggested: I recommend adding the following interview questions: _____ 7: What strategies do you use to address health care outcomes? a. The question is directly relevant to Research question - Keep as stated b. The question is irrelevant to research question – Delete it c. The question should be modified as suggested:

Table 4

Research Questions and Corresponding Interview Questions

Research Questions	Corresponding Interview Questions
RQ1: What challenges are currently faced by healthcare leaders to address current issues of patient outcomes?	IQ 1: Tell me about your career? IQ 2: What are the challenges you face regarding influencing healthcare outcomes? IQ 3: What cultural barriers do you face with diverse communities?
RQ 2: What are the current strategies and practices are employed by healthcare leaders to influence healthcare outcomes?	IQ 4: What strategies do you use to incorporate your strengths in your leadership role that influence health outcomes? IQ 5: What strategies do you use to address cultural barriers?
RQ3: How are successful healthcare outcomes defined, measured, and tracked?	IQ 6: How do you measure and track success in health outcomes? IQ 7: How do you measure and track cultural barriers and diversity?
RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?	IQ 8: What recommendations can be implemented to provide solutions to improve outcomes? IQ 9: What lessons will you share with emerging healthcare leaders? IQ10: What mistakes have you made and what lessons have you learned from? IQ 11: What systemic recommendations will you implement to improve outcomes?

Note. The table identifies four research questions and corresponding interview questions. Interview questions were reviewed by a panel of two peer reviewers and expert reviewers.

Table 5

Research Questions and Corresponding Interview Questions (Revised)

Research Questions	Corresponding Interview Questions
RQ1: What are the challenges you face regarding influencing healthcare outcomes?	IQ 1: Tell me about your career? IQ 2: What are the cultural challenges you face regarding influencing healthcare outcomes? IQ 3: What cultural barriers do you face with diverse communities?
RQ 2: What strategies do you use to address these challenges and barriers?	IQ 4: What strategies do you use to address cultural challenges and barriers? IQ 5: What strategies do you use to address diverse communities?
RQ3: How do you measure and track your success with overcoming challenges and barriers?	IQ 6: How do you measure and track success with cultural barriers in achieving health outcomes? IQ 7: How do you measure and track your success with diverse communities? IQ 8: How do you measure and track success in other areas?
RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?	IQ 9: What mistakes have you learned from and what lessons have you learned? IQ10: What lessons would you share with emerging healthcare leaders? IQ 11: What recommendations would you make to improve outcomes?

Note. The table identifies the research questions and corresponding interview questions with revisions based on feedback from peer reviewers and an expert reviewer.

Statement of Personal Bias

Cresswell (2014) suggested researchers should clarify the bias they bring to the research. The self-reflection enables an open and honest narrative for the reader (Creswell, 2014). From the researcher's perspective, while there was much in the public discourse on the cost of healthcare and new reforms instituted, there was little discourse on the impact leaders may have in improving health outcomes. Thus, the researcher pursued this project based on personal experience witnessing the current state of health across disparate and non-disparate subgroups. There were no benefits financially to the researcher and any costs incurred in the conduct of this study were solely from the researcher. There were no personal affiliations with any of the study participants. The researcher's extensive career in U.S. healthcare, pharmaceutical leadership, and academic pursuit in the study of leadership shaped the researcher's perspective on successful strategies for health care leaders to remove disparities and improve health outcomes. The researcher's bias toward the gap in healthcare leadership in addressing outcomes may have had an effect on the study design and methodology.

Limitations

The researcher selected qualitative design as this method of inquiry would elicit insight into the challenges of healthcare leaders with respect to disparities in healthcare. Limitations of the qualitative design reflected the scope of the sample size, length of time of the study, and access to specific patient information. The small sample size of 15 participants may limit the generalization of data. The breadth of respondent differentiation may have been impacted by geography. HIPPA privacy laws regarding patient records on disease and health care may have limited access to data. Ethnicity data and demographic data are vitally important in predicting the burden of disease and economic indicators that may peak in various populations and for

allocation of resources. Lastly, quantitative research may offer robust data in disease outcomes and fiscal impact.

Bracketing

A phenomenological study is predicated upon a group or individual having comprehension of a given phenomenon. Phenomenology also requires a baseline understanding of assumptions and biases held by the researcher to refrain from impacting the validity of a study. However, it is difficult for researchers to approach inquiry of a topic for the first time. Thus, bracketing is effective to disassociate the researcher's personal experiences with the phenomenon studied. Bracketing is a term used to describe the process of researchers putting aside information learned from the literature or experiences to approach their research with an open perspective (Boeije, 2010). The strategy of bracketing was used to help comprehend the assumptions and inherent biases, and the underlying subjective experiences. Researchers explain experiences gained through personal observation with the phenomenon and exclude their perceptions prior to moving forward with the views from participants (Creswell et al., 2007). Bracketing allows for those subjective experiences and biases to be understood, but the focus filters solely on the experience of the participants in the study, and how they experienced the phenomenon (Creswell, 2014).

Epoche

For this study, the researcher listed all causes of health disparities and potential health leader's challenges, as well as leader strategies to narrow the gap in disparities and improve health outcomes. The assumptions and biases were bracketed into themes and were considered comparatively with the thematic results of the study. The concept of epoche was instrumental for the investigator to remove her personal experience in healthcare and have a fresh perspective

(Creswell et al., 2007). Also referred to as transcendental, epoche allowed everything to be received as for the initial time (Creswell et al., 2007). Epoche allowed the researcher to separate potential biases on the phenomenon studied to remain open to the experience (Moustakas, 1998).

Data Analysis

For this research study, the data analysis process involved the use of a constant comparative analysis of one segment of data to another to determine similarities and differences. Data were coded to identify common themes and categories. The researcher utilized this inductive process by reviewing field notes and transcriptions after the completion of each interview. For this research study, the data analysis process involved the use of a constant comparative analysis of one segment of data to another to determine similarities and differences. The researcher analyzed and transcribed the interview data by utilizing notes, data entry and storage, and coding. Notes were written when ideas or insights emerged from personal observations of the participants, as well as from interview responses that may have led to follow-up questions. Data gathered from the interview process, memos, and observational notes were transcribed.

Interpreting Data: Coding

Data were coded to identify common themes and categories. The researcher utilized this inductive process by reviewing field notes and transcriptions after the completion of each interview. The transcribed data were then segmented into codes. Inductive coding was selected as the analysis approach. Inductive coding is used when the researcher does not bring a predetermined idea of what types of codes to use during the coding process. An inductive coding procedure was utilized that began with an interim analysis. Next the responses were coded and bucketed into themes. Finally, these themes were examined to provide explanations of

the problem of significance. The inductive approach is used frequently as part of qualitative data analysis within grounded theory (Strauss & Corbin, 1990).

The reasons for utilizing an inductive approach are to build data from participants and transform data to broad themes applicable to a model or theory (Creswell, 2014). The themes identified were then correlated with the participant's responses and literature reviewed. From this study's inductive analysis, themes emerged from participant responses. During the coding process, a master list was kept of all the commonalities, codes, and potential themes discovered during the coding process. The results of the coding helped answer the research questions succinctly and directly. The researcher utilized the coding process to create categories within the inductive analysis process. The labeling, description, text, links, and associated models helped to connect the categories to the research questions.

After the initial coding, to establish interpreter reliability, a co-reviewer process was employed. Two external co-reviewers individually assessed the researcher's coding. These co-reviewers were experienced in both qualitative and quantitative research and have done extensive research in the study of leadership. Upon completion of the co-reviewers' assessments, a discussion was held between the researcher and the reviewers, and clarifications and revisions were made. The results of the coding were transferred into themes correlated with the research questions and are presented in Chapters 4 and 5.

Interrater Reliability and Validity

To achieve reliability, participants were asked the same survey questions with the same instrument. Consistency in administration and selection of participants ensured reliability. A multi-step procedure was used to ensure inter-rater validity and reliability.

Step 1. The principal researcher first open coded three of the transcripts individually for the process to stratify, examine, compare, conceptualize, and categorize information (Strauss & Corbin, 2007).

Step 2. Results of the individual coding process for the first three transcripts were reviewed by two peer reviewers with the goal of achieving consensus regarding the individual coding results.

Step 3. Once the peer reviewers arrived at consensus in terms of the based on agreed methodology, the remainder of the transcripts were coded.

Step 4. When discussion between the researcher and the reviewers did not result in unanimous agreement, the unresolved points were presented to the dissertation committee to decide on final coding results.

These reviewers were doctoral candidates in the EDOL program at Pepperdine University. The peer reviewers had previously completed two doctoral courses in qualitative methods and data analysis, and both were completing dissertation work using a similar coding procedure. The coding process (Boeije, 2010) and the coding results were presented to the evaluators for verification. Recommendations for revisions to the resulting codes and categories were discussed between the researcher and the two external reviewers. The coding results were accepted only when both the reviewers and the researcher agree on their validity.

Summary

This research objective identified leadership strategies to effectively improve health outcomes**.** A **c**omprehensive and extensive examination of the research design, methodology, and techniques for conducting valid and reliable qualitative research were explored. The research approach was classified as a descriptive design using a qualitative approach with an objective to

glean the leadership strategies best employed to effect disparities and challenges to improve healthcare outcomes. Qualitative methodology of phenomenology elicited data from research participants via semi-structured interviews. Maximum variation drew a distinct array of participants who contributed to the researcher's aim to collect data from the participants' lived experiences. The sample of 15 participants was chosen based on specific inclusion and exclusion criteria. Data collection was focused on the leadership effectiveness of authentic senior leaders at a large healthcare company. These data were used to determine best practices and challenges in leadership and offer advice for future leaders. After receiving approvals from each participant, site leaders, and Pepperdine's IRB, targeted human subjects received an invitation (see Appendix C) explaining the study and inviting them to be part of it. During this initial contact of the final list members, the approved IRB recruitment script was followed. Consistency in administration and selection of participants insured reliability. To achieve reliability, participants were asked the same survey questions with the same instrument.

Chapter 4: Findings

Introduction

Given that the U.S. outspends all nations in healthcare delivery but has the worst outcomes and that treatment outcomes do not come close to matching levels expected for those expenditures, this research was intended to contribute to the repertoire of existing research and propose strategies for immediate planning, implementation, and future recourse. There are data to support the theory that disparate results in care are a result of the inequities of the healthcare system. The focus area for this paper was to explore the existing state of healthcare, causes of disparities, and health care policy. An evaluation of leadership strategies identified the role leaders have in supporting the healthcare needs of many with respect to cost, access, affordability, and outcomes.

The intent of this study was to identify factors impacting healthcare and to associate strategies employed by healthcare leaders to improve healthcare outcomes for patients in the U.S. Understanding the strategies implemented for improved health outcomes for leaders will contribute to the study of health outcomes and the causal contributors of disparities, leadership, cultural competency, health reform, and social determinants.

The research questions that guided this study were:

RQ1: What are the challenges you face regarding influencing healthcare outcomes?

RQ2: What current strategies do you use to address these challenges and barriers?

RQ3: How do you measure and track your success with overcoming challenges and barriers?

RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?

Data Collection

The participant selection process employed purposeful sampling. Data were collected from the 12 healthcare leaders during the semi-structured interviews scheduled between March 6, 2018 and April 2, 2018. An e-mail was sent to all potential participants explaining the purpose and criteria of the study. The informed consent and interview questions were distributed to participants who confirmed their participation. As the participants met all criteria and confirmed their participation, the researcher requested dates within a specific timeframe that were convenient for the participant's schedule. All participants suggested the mode of communication or method of meeting: (a) face to face, (b) phone, or (c) Skype.

Before interviews commenced, the participants were asked: (a) to provide a verbal consent, (b) if they had any questions on the purpose of the study, (c) to sign the informed consent, and (d) if they had any questions about the process. All 12 participants were informed of the recording and when the audio recording would begin and end. The interviews lasted between 20 and 60 minutes. Two audio devices were used for recording the interviews. The audio files were securely stored during the transcription service and the audio files were erased after final defense. The participants, interview dates, and interview methods are shown in Table 6.

Table 6

Participant Interview Dates and Interview Methods

Participant	Interview Date	Interview Method
P1	March 6, 2018	Face to face
P2	March 14, 2018	Face to face
P3	March 16, 2018	Skype
P4	March 16, 2018	Phone

(continued)

Participant	Interview Date	Interview Method
P5	March 22, 2018	Face to face
P6	March 22, 2018	Face to face
P7	March 23, 2018	Skype
P8	March 26, 2018	Skype
P9	March 26, 2018	Face to face
P10	March 30, 2018	Phone
P11	April 2, 2018	Skype
P12	April 2, 2018	Face to Face

Participant Demographics

Using the inclusion and exclusion criteria detailed in Chapter 3, a master list of 35 individuals was generated. An invitation to participate was sent to the 35 potential targets via e-mail using a public e-mail address. Of the 35 individuals invited to participate, 15 agreed to participate and be interviewed for the study. Three did not interview due to last minute scheduling conflicts. Ultimately, 12 participants were interviewed for the study.

Gender. The participants who contributed to the study included eight males (67%) and four females (33%). Figure 1 details the gender distribution of the participants.

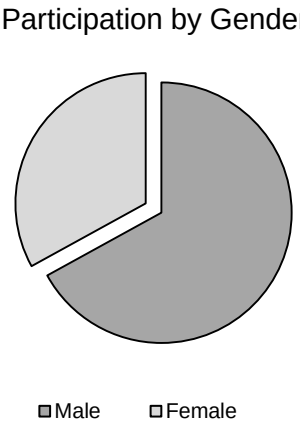

Figure 1. Participation by gender.

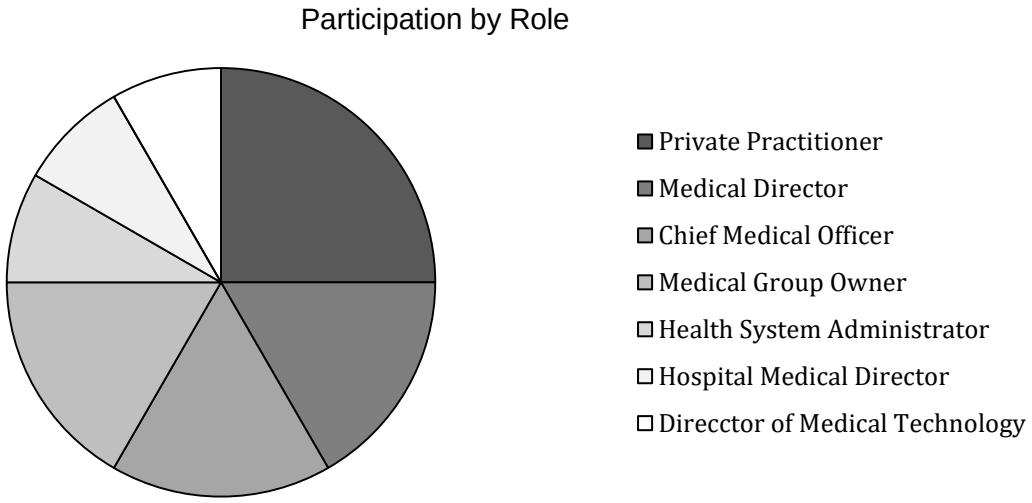

Figure 2. Participant expertise in healthcare leadership by position title.

Participant expertise in healthcare leadership. The 12 participants held various roles in healthcare leadership, such as medical director, chief medical officer, health plan director, medical group owner, hospital director, and private practitioner. Two participants were medical group owners, two were medical directors, one was a hospital medical director, one was a health system administrator, two were chief medical officers, one was a director of medical technology, and three were private practitioners. Figure 2 highlights the professional designations of the 12 participants.

Data Analysis

The data analysis process in this qualitative study was designed to ensure the participants could explore their lived experiences in healthcare leadership to address the research questions. Based on the participant's experiences, knowledge of the healthcare field, and specialization, themes were elicited that were pertinent to the research. The semi-structured interviews were transcribed from the 12 interviews into 12 Word documents. Next, a spreadsheet was created to populate the participant's responses into themes. The spreadsheet contained the interview

questions and columns for each participant's core answers. Unique identifiers were assigned to each participant to protect their identity and privacy. The responses from the participants were color coded based on themes and groupings. The color-coded categories were notated for frequency of the common themes. Three or more groupings were identified by the researcher to validate the similar responses of the participants into common themes.

To execute external validity, the researcher partnered with doctoral alumnus who were proficient in qualitative research and analysis to review the coded themes from the interviews. A multi-step process was followed for the raters to review the themes, offer suggestions to name the categories, and align the topics into the appropriate category. The raters' recommendations were as follows:

- IQ1: The number of job categories was reduced from nine to five; practice specialties (i.e. nephrologists, cardiologists) were combined into private practitioner.
- IQ2: The number of themes was reduced from seven to four, drug formulary was combined with insurance, and lack of resources and medical guidelines were eliminated.
- IQ3: The number of themes was reduced from seven to four: education, technology, and age of population were removed.
- IQ4: The theme team approach was renamed to patient focus.
- IQ5: No changes to themes.
- IQ6: The theme called diagnosing was renamed to patient care.
- IQ7: No changes to themes.
- IQ8: The theme named access was renamed healthcare insurance, and the theme pathophysiology was renamed diagnosis and treatment.

- IQ9: The number of themes was reduced from five to four; the theme named educate was removed.
- IQ10: No changes to themes.
- IQ11: Themes were increased from three to four as the theme health insurance was added.

Data Display

The following data and findings are from the data collected from the semi-structured interview responses for this research study. The interview questions contain additional details for the developed themes from transcribed data. Graphs show the frequency of answers associated with the common themes. Thirty-nine themes emerged from the 11 interview questions. Participants in the study were referred to P1 through P12, to protect the human subject's privacy and confidentiality.

Research Question 1

This question asked, "What challenges are currently faced by healthcare leaders to address current issues of patient outcomes?" This research question comprised the following interview questions to gain the 12 participant's insights and experiences:

- IQ1: Tell me about your career.
- IQ2: What are the challenges you face regarding influencing healthcare outcomes?
- IQ3: What cultural barriers do you face with diverse communities?

Interview question 1. This question asked, "Tell me about your career." Based on responses recorded from the participants related to the challenges currently faced by healthcare leaders to address current issues of patient outcomes, the following themes emerged: (a) medical group owner, (b) health system administrator, (c) medical director, (d) private practitioner, (e)

chief medical officer, (f) hospital medical director, and (g) director of medical technology. Figure 3 shows the number of participants in each category.

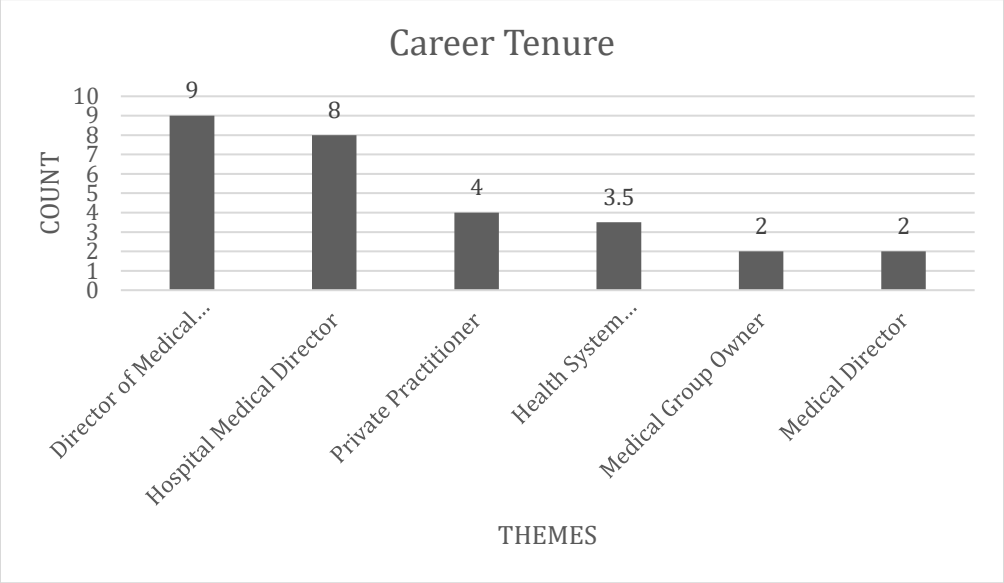

Figure 3. IQ1: Themes from participant responses on their careers.

All the participants had been leaders in their healthcare field of expertise with greater than 20 years in practice. All participants, except P8 (director of medical technology), had a designation and experience as a medical doctor. All participants had patient-facing roles during their careers as a health care leader. These roles were:

- Medical director (P2, P5)
- Medical group owner (P1, P3, P11)
- Health system administrator (P12)
- Private practitioner (P9, P10)
- Hospital medical director (P6)
- Director of medical technology (P8)
- Chief medical officer (P4, P7)

Interview question 2. "What are the challenges you face regarding influencing healthcare outcomes?" According to the responses recorded from the participants related to the research question on the challenges leaders face to address issues in healthcare outcomes, four main themes were identified: (a) insurance, (b) patient education, (c) delivery of care, and (d) social determinants of health. Figure 4 shows the number of responses to each theme.

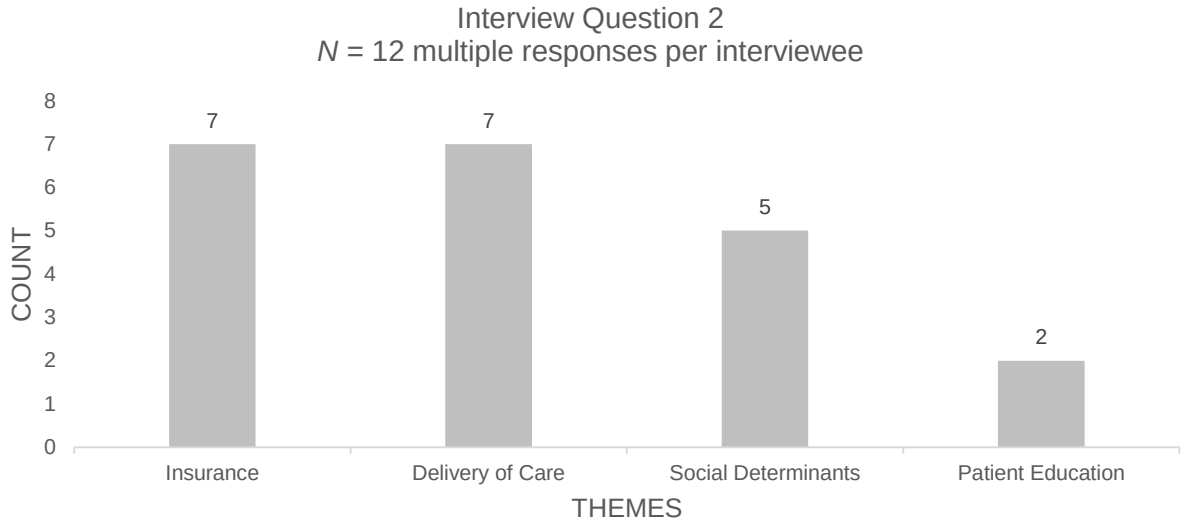

Figure 4. IQ2: Themes developed on challenges faced influencing healthcare outcomes.

Insurance. Seven of the 12 (58%) stated insurance presents a challenge in achieving outcomes. The insurance was described as the patient's ability to pay, insurance disparity, physician reimbursement, the PPO/HMO plan benefits, for-profit insurance, and drug formularies. The response of P2 was underscored by multiple participants:

> Because of disparity in health insurances, we're not able to care for our patients the way we were taught to care for them and are expected to take care of them. More importantly, not being able to take care of every patient equally.

The response of P1 further explained the challenge of the PPO/HMO structure: "physicians are hogtied by insurance regulations and we need to explain ourselves to secretaries, nurses, and physicians to get what we really need to get done." P12 commented that "the most

frustrating to me is if I have a situation that I know something will help a patient and I can't get it approved and the patient has to suffer." P1 commented on the for-profit insurance and disparity "we are now transitioning from a Blue Cross/Blue Shield type where there's 80/20 on the patient's part to more of a socialized medicine."

Another example shared by P3 was the increased utilization of hospitalists that only work in hospitals to admit and follow all patients in an institution. The new PPO/HMO models do not allow the patient's healthcare provider to treat inpatients. According to P3:

> Hospitals and medical groups are not allowing the physician to see their own patients in the hospital. There is no way a doctor who has known you for 10 years can have care rendered for their patient by a hospitalist who has seen you for 30 minutes.

The response of P6 underscored the challenge of drug formularies, "a lot of medication is not approved by the insurance, requires prior authorization which takes time and effort." In contrast, P8 addressed the issue of physician reimbursement as value-based incentive models that tie risk to the healthcare provider to achieve better health outcomes for their patient population.

Delivery of care. Seven participants mentioned that delivery of care and services plays a significant role in addressing healthcare outcomes. Among the descriptors of delivery of care were socialized medicine guidelines, medically underserved populations, time to follow-up, technology, hospitalists, and equality of care. P6 commented that a common challenge when treating the medically underserved populations was the lack of health records. Not all health systems were using electronic health records. P6 stated that "hospitals and health systems have their own records and patients show up here and we don't know anything about them and that basically would change the outcome."

The change from non-profit to for- profit care models was mentioned by several healthcare leaders as a challenge that influenced outcomes. P11 commented on delivery of care, and stated:

> Care is going down and down all the time. HMOs have a lot of paperwork, take a lot of money and did not change the prices for the people. It's a limitation for the patients and I think less service delivery." P3 further commented on the new medical and HMO guidelines that limit routine check-ups and procedures while expecting providers to achieve reasonable outcomes limiting untoward problems secondary to poor care.

***Social determinants of health*.** Five participants detailed the social determinants of health as a challenge that influenced health outcomes. Among the types of social determinants of health were a patient's lifestyle, demographics, poverty, family/culture, and transportation. Social determinants of health often determined whether patients were going to be successful in achieving outcomes. P4 discussed the importance of addressing the social determinants prior to treating disease. According to P4:

> You must look at the proximate causes of their problem, the root causes patients are not compliant to the regimen. An example is a patient who needs to care for their diabetes and you discover they have housing or food insecurity. They could have children in that situation. You must address those things first to address their diabetes.

The disparities in access to quality food in impoverished areas was commented on by P5 and P8; P8 said that "the demographics is a socioeconomic problem, because better outcomes and better care go beyond the treatment modality of the patient in the clinic." The patient's support system

of family, culture, and access to food, can all help a patient's desire to be compliant (P5, P4, P8). Additionally, P8 stated that "from a provider level, you try to treat everyone with an equal standard. You run into socioeconomic issues, when patients are not on an even standard of nutrition, health status, transportation, and living environments."

Patient education was another challenge identified in influencing healthcare outcomes. Health literacy and the patient's education level were noted as challenges. With respect to health literacy, P5 stated:

> Patient education level is a challenge. Our Latino diabetic community think insulin is going to kill them and make them go blind. We have nurse educators, case managers, and we all work to try to overcome the challenge of lack of education.

P9 and P6 concurred, and P9 shared that the challenge was in educating their patients to take care of their health. P6 said that having time to follow up and provide basic education would make patients more compliant, which would affect the outcome.

Interview question 3. "What cultural barriers do you face with diverse communities?" Input from the healthcare leaders constructed three themes that included: (a) cultural competencies, (b) insurance, and (c) social determinants. Figure 5 presents the number of responses for each theme.

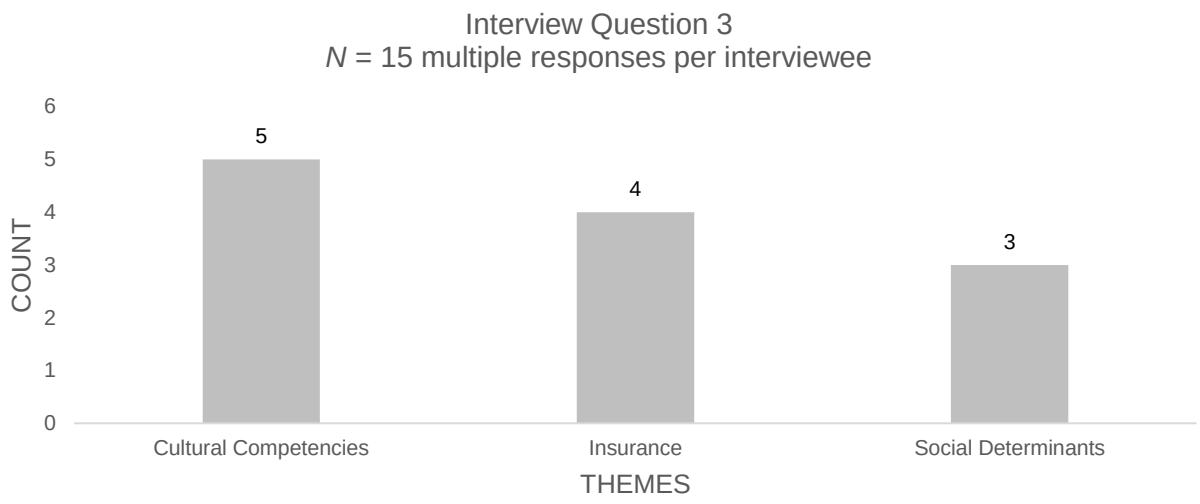

Figure 5. IQ 3: Themes on cultural barriers faced in diverse communities.

***Cultural competence*.** Five of the 12 (67%) participants indicated that cultural competency was a barrier in diverse communities. Interestingly, this was viewed from two perspectives, and one perspective was a minority healthcare provider and how that person experienced cultural competency from patients. P1 commented, “I don’t have a lot of cultural issues, probably because I’m brown and I went to a school with mostly African Americans.” P3 discussed her experience as the only African American specialist at her institution and how she hid her ethnicity from media so as not to deter patients from seeking her care. P7 addressed how cultural confidence is needed for health equity for factors such as healthcare education and health literacy. P7 stated, “in order to address people’s needs, you have to meet them where they are in a culturally confident manner.” P12 stated the cultural barriers he faced with patients was due to the level of education and the perception and age of the patient. He said the older patients were more trusting and compliant, while younger patients referred to Google and friends for health advice.

P6 and P5 illustrated how family and religion can introduce barriers. Religious beliefs that people have might change the outcome of different treatments (P6) and familial influence in

not trusting western medicine (P5). Cultures and traditions of families can be barriers to care. P4 stated that "African American patients would like to keep their loved ones at home rather than a nursing home, where there are not many homecare practitioners in those environments to support and build bridges."

Language also was presented as a cultural barrier. P10 and P6 referred to language as a barrier for the provider and patient. P10 stated "my Spanish is not really enough to take care of someone who is primarily-Spanish speaking, so I use translators." The use of interpreters as a resource was also presented as a barrier. P6 stated that "language is a barrier when you always use an interpreter. It's not the same when you're speaking in the patient's own language."

Insurance. Four of the 12 participants indicated insurance issues were cultural barriers with diverse communities. Patients who had insurance may not have understood the benefits and limitations of their health plans. P4 shared the following example, "many people assume that Medicare was going to cover their basic need, though they don't understand Medicare only covers medical needs, but not social needs." P2 stated that "90% of our time goes towards managing the disparities in insurance practices. By the time we're done with that we're so exhausted, the patient is so exhausted, they don't even think about cultural disparities." P11 commented on the lack of regulation of insurance companies and private companies where there is no control, "every day there is more pressure for doctors and they are limited. They cannot do what they want." Access to healthcare was brought up by P6 and he noted, "kidney disease is highest among the African American and Hispanics and they don't have as much access to healthcare."

Social determinants. Lastly, three of the 12 participants indicated that the social determinants of health contributed to the cultural barriers in diverse populations. Determinants

such as housing, food, poverty, health literacy, and language presented common cultural barriers. P7 commented on health literacy and healthcare education as factors that could improve health equity. P12 said that one barrier was the level of education of patients and their perception of what goes on. P6 also commented that when language barriers existed, providing patient education thru translators or family members was effective.

Secondly, food equity was a social determinant in the status of health between impoverished areas and affluent demographics. According to P8, "if you go to Napa Valley, dialysis patients are eating salads and fresh organics and vegetables and proteins than if you go to the some of our inner-city clinics." Additionally, P8 equated nutrition as a socioeconomic factor.

Research question 1 summary. "What challenges are currently faced by healthcare leaders to address current issues of patient outcomes?" The subsequent interview questions were asked:

- IQ1: Tell me about your career.
- IQ2: What are the challenges you face regarding influencing healthcare outcomes?
- IQ3: What cultural barriers do you face with diverse communities?

The interview questions addressed the familiar challenges healthcare leaders faced. Issues regarding insurance, patent education, delivery of care, and social determinants of health were noted by the participants. Cultural barriers in diverse communities elicited participant responses on cultural competencies, insurance, and social determinants. Recognizing and addressing social determinants of health was viewed as a precursor to treating patients medical condition. The themes from Research Question 1 are summarized in Table 7.

Table 7

Summary of Themes for Research Question 1

IQ1. Tell me about your career	IQ2. What are challenges you face influencing health outcomes	IQ3. What cultural barriers do you face with diverse communities
Medical director	Insurance	Cultural competencies
Medical group owner	Delivery of care	Insurance
Health system administrator	Social determinants	Social determinants
Private practitioner	Patient education	
Hospital medical director		
Director of health technology		
Chief medical officer		

Research Question 2

Research Question 2 asked "What are the current strategies and practices employed by healthcare leaders to influence healthcare outcomes?" This research question comprised the below interview questions to elicit responses from the 12 participants involved in the study:

- What strategies do you use to incorporate your strengths in your leadership role that influence health outcomes?
- What strategies do you use to address cultural barriers?

Interview question 4. The question was "What strategies do you use to incorporate your strengths in your leadership role that influence health outcomes?" The themes that emerged from the participants included Patient focus, patient outreach, economics, communication, and social determinants. Figure 6 presents the themes and the number of participants mentioning a theme.

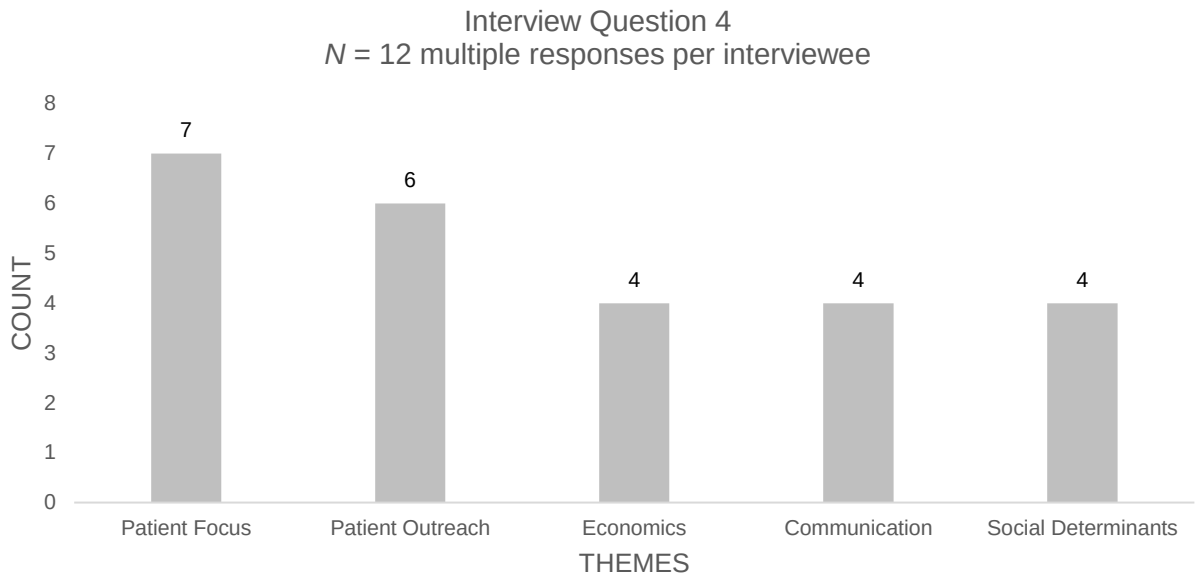

Figure 6. IQ4: Themes on strengths in leadership role that influence health outcomes.

Patient focus. Based on the responses, seven out of 12 (58%) participants shared that patient focus was a leadership strategy employed to influence health outcomes. Patient focus included factors such as patient centered care, specialty intervention, team approach, primary prevention, early detection, and trust of patients. Having a team approach was mentioned by P7 and P5. The team approach can uncover community resources as well as mobilize the team to work as a unit. P5 shared that:

> We have case managers, clinical pharmacists and nurse educators who work to overcome the challenges of lack of income, lack of education, and other socioeconomic factors. We must get away from the traditional approach where the nurse calls each member to influence by phone. It may make more sense to visit these members face-to-face.

Patient outreach. Based on six out of 12 (50%) of participants responses, patient outreach was considered a strategy employed to address healthcare outcomes. Factors of patient outreach discussed included community resources, family outreach, community partnerships,

family education, and tailored programs. P7 and P5 discussed the importance of designing programs for patients that addressed their specific needs. They also commented on the need to build alignment with the community to partner for resources.

An example shared by P7 was the use of La Promotoras in Hispanic communities. This organization provided community liaisons who spent time with patients in their homes to educate, provide care, assist to secure needed services, and provide health education with individualized and cultural attention. P5 shared how his medical team increased outreach to educate the care team with weekly and monthly meetings to educate themselves on the patient dynamics. In addition, P5 believed that healthcare leaders must remove themselves from technology to communicate with patients. He initiated a model for health care professionals to invest in quality communication with patients to reach out to patients via telephone for follow-up. P5 did believe the use of EHR technology could assist with outreach to medical specialists who can provide services to the underserved population. Trust was also a common factor mentioned as a strategy. P2 said that "trust impacts outcomes by allowing me to focus on the outcomes for my patients."

Education of a patient's family was discussed as a tool to improve health outcomes. Education of the patient, family members, and caregivers were all identified as examples of leadership expertise practices that made an impact in achieving health outcomes. There was a commonality from physicians who treated lower income patient populations and the time they spent educating patients on disease, treatment, diet, exercise, and resources. The physicians who had patient populations in higher income communities stated their patients came to their appointments fully equipped with articles from the internet, knowledgeable and prepared to challenge physicians.

Economics. Responses from four of the 12 (33%) of participants indicated economics was incorporated into strategies employed to influence healthcare outcomes. Economic factors included corporate savings, costs, utilization of services and resources, and reduced hospital admissions and re-admissions. P7 shared that corporate healthcare leaders measured outcomes in terms of savings. An example P7 shared was that by improving disease outcomes you could prevent the patient from being readmitted to the hospital or increased ER visits, or fewer days in the hospital. These are types of savings that could be measured and strategized.

Also, the participants commented on recognition from the local community and specific populations. Participant 7 stated "when you notice costs in certain populations are increasing, you may be able to identify that in an HIV population, your costs may be three to four times higher than your baseline population." A unique perspective came from P2 and P11, who believed physicians increased their expenses due to the lack of coverage from insurance companies. To protect themselves from malpractice, physicians must order additional tests for patients that may not be reimbursable to improve outcomes, thus reducing their revenue.

Social determinants. Four of the 12 participants emphasized the importance of including social determinants in employing strategies and practices to influence healthcare outcomes (P4, P5, P8, P12). Facets of social determinants included family outreach, education, quality of life, and poverty. P5 noted the challenges of discussing food groups and healthy eating when the patients were impoverished and unable to get food on a regular basis. In addition to food and nutrition concerns, P12 and P4 commented that family stressors, lack of transportation, financial problems, and education of patients all contributed to health outcomes. There was a consensus that health outcomes cannot be achieved without consideration of social determinant factors.

Communication. Four of the 12 (33%) participants conveyed that communication was a strategy used to incorporate their strengths into their leadership roles (P6, P5, P7, P12). Technology played a role in communicating across the health care spectrum as a team approach. P5 described how electronic health records provided direct access and direct communication among health care providers contributing to patient centered care. “EHR not only benefits the patient but educates the health providers as well” (P5). P7 found value in getting away from the traditional communication style of phoning patients at home. He espoused face-to-face interaction to learn more about the patients and influence their behaviors.

P12 and P6 incorporated a strategy to use translators to address language barriers with patient communication and not rely on family members to interpret for patients. “Interpreters are professional and well-trained and do incorporate bias” (P6).

Interview question 5. “What strategies do you use to address cultural barriers?” Input from healthcare leaders constructed four themes: (a) eliminate bias, (b) community outreach, (c) communication, and (d) education. Figure 7 presents the themes and the number of responses for each theme.

Figure 7. IQ5: Themes on strategies used to address cultural barriers.

***Community outreach*.** Five of the 12 (41%) participants indicated that community outreach was vital to addressing cultural barriers. The following characterizes how the participants used community outreach as a strategy in addressing cultural barriers (P4, P5, P6, P7, P8):

- Identify the needs of the community and what resources are available in a community (P7).
- Retain interpreters to represent the demographic makeup of the community (P6)
- Provide at home training and education for patients and family members for chronic diseases like chronic kidney disease and dialysis (P5, P6).
- Visit the inner-city clinics and observe the situations those clinics face. Have forums with patients going thru the same problems. Listen to them and their caregivers to understand their challenges (P4, P8).

A participant discussed how "partnerships with community organizations that patients trust is important to be successful" in designing community outreach programs (P7).

Communication. The theme from this interview question elicited communication as a strategy used to address cultural barriers by four of the 12 participants (P3, P4, P5, P10). There were many ways communication served as a strategy. P10 discussed the importance of communication with a patient's primary and specialty physicians. P4 and P5 executed communication using electronic medical and health records across all facets of the patient's care team on a regular basis. P4 also discussed patient self -determination and communicating from a patient's perspective including input from family members. P3 practiced in a diverse patient population and felt it was necessary to "reciprocate to make patients feel the most comfortable, whether they are from an all-Black community or a white-collar executive" (P3).

Eliminate bias. Four of the 12 participants referred to eliminating bias as a strategy to address cultural barriers (P1, P2, P3, P6). Two of the healthcare leaders, who represented minority groups, discussed how they eliminated bias from patients. P3—an African American female—posted no photos of herself on any of her social media, hospital, or private practice website. She stated that she was a highly competent healthcare leader and wanted patients and health leaders to judge her when they met her and communicated with her one-on-one. P1—an African American male healthcare IPA group leader—talked about how he led by keeping a low profile and letting his work speak for him. He shared that he started his day earlier than anyone and worked later. He was always accessible for his patients.

The bias in healthcare insurance was voiced by all four participants and identified as a strategic focus. Managing insurance disparities was a topic broached by all four participants. P6 indicated that "in the patient population with chronic disease, people don't have insurance. When people don't have access to insurance, this will affect the lower socioeconomic class. The higher already have insurance" (P6). P2 was passionate describing the strategy he implemented to address insurance bias. He stressed the importance of listening to the patient communicating how to correct their need. He emphasized focusing on preventative health for all. He took all avenues to address a patient's insurance concerns.

Education. Three of the 12 participants indicated that thru education, healthcare leaders felt they were successful addressing cultural barriers. The participants referred to the significance of giving patients ownership in their healthcare. "If patients are actively involved in their healthcare, I think they will have better outcomes" (P12). P4 stressed the value of anticipatory guidance and education for middle aged, elderly patients, and caregivers' knowledge of Medicare and long-term care insurance resources. Patient education and empowerment were

further supported by P8: “when patients have better knowledge, they begin to ask better questions about nutrition, diet, and adherence.” Education was also a component of cultural barriers. All participants spoke to cultures that have norms and do not readily seek, have access to, or trust western medicine. The healthcare leaders strategically followed these patients more closely.

Research question 2 summary. The research question asked, “What are the current strategies and practices employed by healthcare leaders to influence healthcare outcomes?” This research question comprised the below interview questions to enlist responses from the 12 participants involved in the study:

- IQ4: What strategies do you use to incorporate your strengths in your leadership role that influence health outcomes?
- IQ5: What strategies do you use to address cultural barriers?

The interview questions revealed strategies and practices employed by healthcare leaders to influence healthcare outcomes. The top themes were patient focus, patient outreach, economics, communication, and social determinants, eliminate bias, community outreach and education. Strategies to educate patients and their caregivers, preventative healthcare, types of communication, patient focus in designing programs and resources, and types of outreach were repeatedly discussed by participants. Understanding patient needs, income restrictions, and social determinants of health were equally identified as strategies. Table 8 shows the interview questions and the themes to emerge from participant responses.

Table 8

Summary of Themes for Research Question 2

IQ4. Strategies to incorporate strengths	IQ5. Strategies to address cultural barriers
Communication	Community outreach
Patient focus	Eliminate bias
Social determinants	Communication
Patient outreach	Education
Economics	

Research Question 3

Research Question 3 asked "How are successful healthcare outcomes defined, measured, and tracked?" The question included the following interview questions to enlist responses from the 12 participants in the study:

- IQ6: How do you measure and track success in health outcomes?
- IQ7: How do you measure and track cultural barriers and diversity?

Interview question 6. "How do you measure and track success in health outcomes?" The healthcare leaders provided insight into their practices in measuring and tracking outcomes. The themes identified were patient care, economic indicators, and follow-up. Figure 8 shows the themes with the number of responses for each theme.

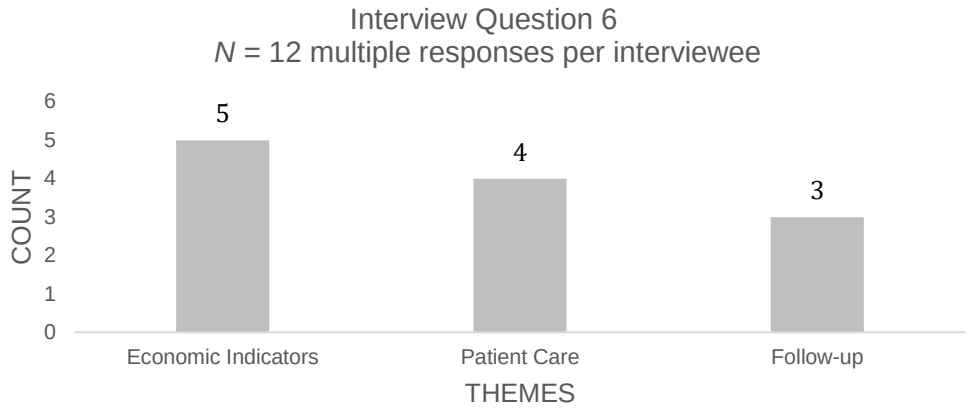

Figure 8. IQ6: Themes on measuring and tracking success in health outcomes.

***Economic indicators*.** Based on responses from five out of the 12 (42%) participants, economic indicators were a reference used to track health outcomes (P3, P4, P7, P8). P3 believed she successfully tracked the outcomes and measured success by the growth of her practice and volume of patients. She did not advertise and believed her patients' satisfaction with their state of health and resolution of disease has catapulted her growth via word of mouth. "I was the third largest practice in the U.S. for five years and have a database of 22,301 patients" (P38). From a corporate health perspective, outcomes were measured and tracked by costs. As discussed by P7, important dimensions of managed care and service performance were measured by HEDIS—Healthcare Effectiveness Data and Information Set. P7 and P8 discussed the costs of utilization of health services as indicators of success. "On the corporate side, you measure your outcome in terms of savings . . . less, fewer days in the hospital" (P7). Preventing hospital readmissions and use of emergency rooms were also identified as tools to measure and track health outcomes (P7, P8). P7 shared an example of reducing ER visits and hospital readmissions by simply providing patients food.

Patient care. Four of the 12 participants commented on several factors of patient care that were instrumental in measuring and tracking success in health outcomes (P1, P6, P7, P12).

P1 and P12 discussed the importance of careful and accurate diagnosis with early intervention as success tools. Resolution and progression of medical conditions were cited by P7 and P6 as ways they tracked and measured outcomes. Quality measures were discussed by all four participants as metrics they used to quantify healthcare processes, outcomes, and patient perceptions related to their quality goals. P6 tracked metrics to follow the chronic disease resolution and non-progression.

Follow-up. Three of the 12 participants (P1, P3, P5) indicated that follow-up was a measure to track success in healthcare outcomes. P1 shared that he did careful follow-up with his patients. He stated that refraining from HMO medicine allowed him to do careful follow-up that resulted in good outcomes for his patients. P3 tracked qualitative data with her patients based on feedback following appointments and medical procedures. P5 found success tracking the patient's attendance with medical appointments. Broken appointment rates could infer the health outcome of his patients like those with HIV and diabetes.

Interview question 7. "How do you measure and track cultural barriers and diversity?" From the responses correlated from the healthcare leader participants, three themes were identified. Common themes that emerged from the participants included programs, quality metrics, and treatment. Figure 9 shows the number of responses for each theme.

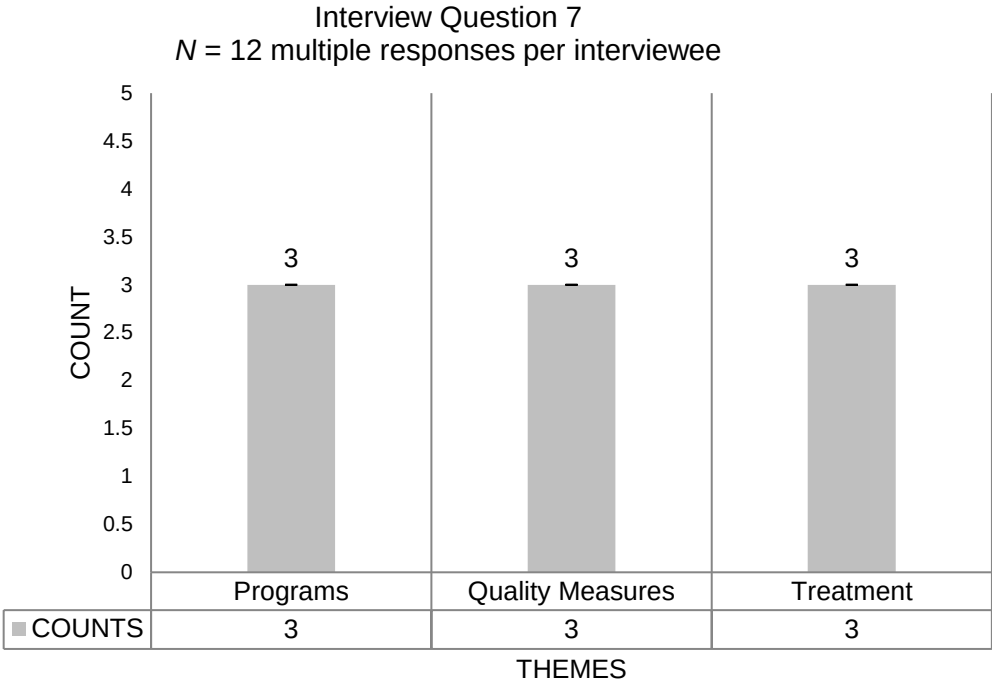

Figure 9. IQ7: Themes on measuring and tracking cultural barriers and diversity.

Programs. Three out of 12 participants responding to this interview question expressed that programs were used to measure and track cultural barriers and diversity (P6, P7, P8). P6 discussed how community partnerships with patient advocacy programs targeted at-risk patients. These programs had success in improving patient targets and goals and enhancing their disease state knowledge, thus improving outcomes. When tracking and measuring cultural barriers and diversity, P7 was emphatic that the problem being examined must be isolated and clear, know what was being done, and know what was being measured. P7 used data and data analyses to identify issues. He incorporated qualitative data from various stakeholders and quantitative insights to develop targeted programs for specific populations.

In addition to developing targeted programs, P8 evaluated how implementation of modern healthcare technology—when could be coupled with collaboration from providers—was

used to create programs on nutrition, body composition, muscle mass, or any outcomes related to patients' socioeconomic situations.

Treatment. Three out of 12 participants discussed types of treatment that could be measured and tracked for cultural barriers and diversity. Cultural consideration of beliefs and customs must be incorporated into decision trees. P12 educated patients and then measured the risks and benefits of healthcare options.

Early intervention was a common theme across all three participants. Although they had not conducted scientific studies for their diverse population, they indicated that early detection and intervention avoided poor outcomes. Individualized care was another approach to treatment that provided direct contact with the patient with personalized care (P3). P7 stated that he used approaches that individualized for a community or for an individual within a community so that treatments addressed a need.

***Quality measures*.** Three out of 12 (25%) participants referenced quality measures used in tracking and measuring cultural barriers and diversity. Adherence to treatment and compliance with healthcare provider instructions could be measured with quality metrics. P9 stated patients were seen regularly every three months to verify compliance with treatment regimens. Quality metrics were used to evaluate outcomes in terms of costs in reducing ER visits, readmissions, and patient education (P7). P5 also tracked quality measures for outcomes, but had a contrary view on their effectiveness: "I'm not sure these measures actually track the difference in cultures or diverse groups. I think that's why we have problems addressing the healthcare disparity between different socioeconomic groups because we don't measure those things very well" (P5).

Research question 3 summary. Research Question 3 posed, "How are successful healthcare outcomes defined, measured, and tracked?" The research question included the following interview questions to elicit responses from the 12 participants in the study:

- IQ 6: How do you measure and track success in health outcomes?
- IQ 7: How do you measure and track cultural barriers and diversity?

The questions in Interview Questions 6 and 7 were designed to identify how health measures were designed to measure and track outcomes, cultural barriers, and diversity. Themes that cultivated discussion included quality measures, treatment, programs, economic indicators, and patient care. A summary of the six themes for Research Question 3 is shown in Table 9.

Table 9

Summary of Themes for Research Question 3

IQ 6: Measuring and tracking success in health outcomes	IQ 7: Measuring and tracking cultural barriers and diversity
Economic indicators	Programs
Patient care	Treatment
Follow-up	Quality measures

Research Question 4

Research Question 4 asked "What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?" This research question included the following interview questions to elicit responses from the 12 participants involved in the study:

- IQ8: What recommendations can be implemented to provide solutions to improve outcomes?
- IQ9: What lessons will you share with emerging healthcare leaders?

- IQ10: What mistakes have you made and what lessons have you learned from?
- IQ11: What systemic recommendations will you implement to improve outcomes?

Interview question 8. "What recommendations can be implemented to provide solutions to improve outcomes?" According to the healthcare leaders on recommendations implemented to provide solutions to improve outcomes, the following themes were identified: reimbursement, access to healthcare, social determinants, and diagnosis and treatment. Figure 10 shows the number of responses for each theme.

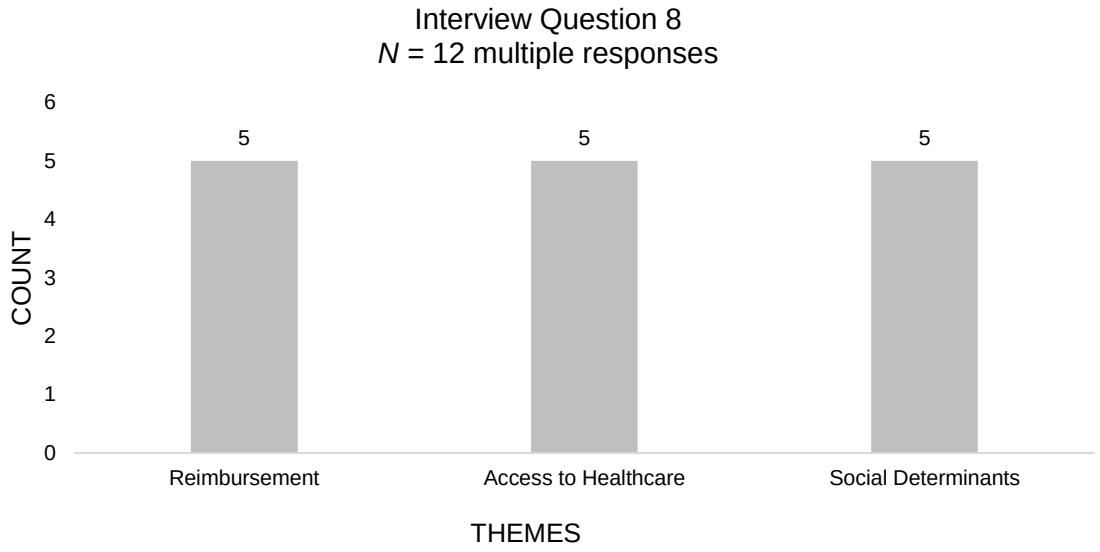

Figure 10. IQ8: Themes on recommendations for solutions to improve outcomes.

Reimbursement. Five out of 12 (42%) participants indicated that solutions to improve reimbursement could be implemented to improve outcomes (P1, P5, P8, P9, P11). One solution was to eliminate withholds and bonuses for keeping costs low for patient care. The current practice of incentivizing physicians for saving money was described as perverse by P1 and P11. They commented that they received money back at the end of the year from insurance plans and medical groups for saving money and both stated that this practice was antithetical to how physicians were trained. Further, through quality measures, physicians were only reimbursed for those disease markers affiliated with expensive chronic diseases. Time spent taking patient

histories was not reimbursed (P5). P8 recommended a collaboration between hospitals and medical providers to improve outcomes. P8's solution was to incentivize providers who kept patients out of the hospital and reduced days of stay.

Access to healthcare. Five out of 12 (42%) participants provided insight into the solution of access to healthcare based on their leadership experience. There were five subthemes that surfaced from their replies including: (a) universal healthcare, (b) Affordable Care Act, (c) free care, and (d) accountable care organizations. All respondents indicated that improving access to healthcare provided three core benefits to all: early detection, prevention, and advances in treatment guideline protocols designed to drive positive outcomes. P1 noted that universal healthcare was a system that could work in the U.S. due to the nature of it being color and financially blind and would move the needle for doctors to care about their patients and practice good medicine. P3 believed that health insurance was already moving to socialized medicine like Europe. Data must be mined to evaluate outcomes limiting untoward problems secondary to poor care (P3).

The Affordable Care Act (ACA) was mentioned by P6 as a solution for lower economic patients to gain access to healthcare. States have created ACA plans that have had some impact (P6). P9 suggested a program that she executed in the middle east that provided free health care to the rural communities with low access to healthcare. New medical graduates provided the free care which provided experience for the doctors and helped the population (P9). P6 and P1 commented on the growth of the Accountable Care Organization (ACO) model. P6 eluded to the advantage of the ACO cost savings model, which aligned hospitals, medical groups, and health plans into one system.

Social determinants of health. Five out of 12 (42%) participants provided insight into the social determinants of health solutions to improve health outcomes (P4, P5, P7, and P8). Where social determinants of health were determinants of health outcomes, the participants provided solutions to address these issues: "Whether patients have health literacy, housing insecurity, or food insecurity, these issues have to be addressed before health issues are addressed" (P7). P7 recommended designing programs and resources in partnership with community organizations. P7 shared an example of a partnership he created with a desert grocery store delivery service to provide fresh produce in rural and impoverished communities. P8, P5, and P7 introduced the use of patient care teams or navigators who tracked the patient care process to ensure compliance and serve as a partner to the patient. Patient navigators also worked within communities, built relationships, and assisted people to received needed services (P7). P5 suggested the inclusion of nurse educators and case managers to overcome the lack of income, lack of education, and other socioeconomic factors. P8 was investigating the use of supplemental nutrition to those patients without income or geographical proximity to purchase organic protein and produce.

Interview question 9. "What lessons will you share with emerging healthcare leaders?" From the responses of the healthcare leaders three core themes emerged: dedication to profession, trust your patients, and continue training. Figure 11 presents the number of responses for each theme.

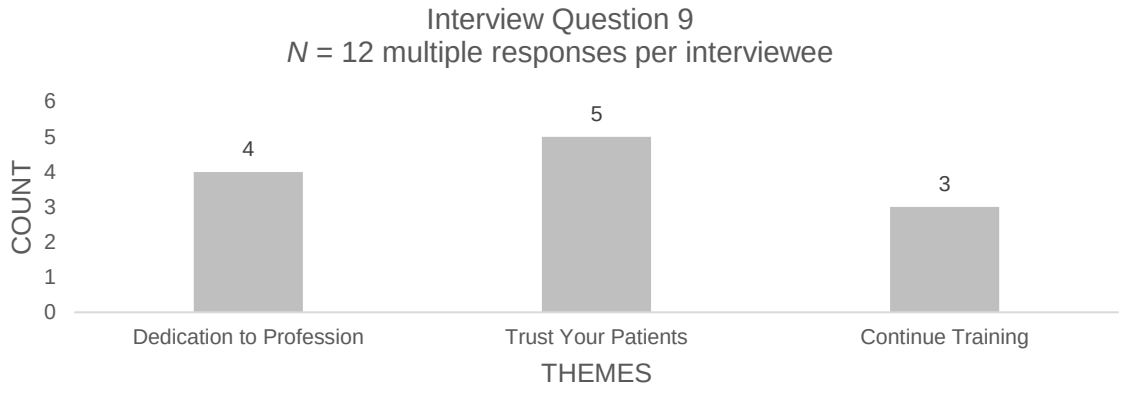

Figure 11. Themes on lessons shared with emerging healthcare leaders.

***Dedication to profession*.** This theme emerged from 4 of the 12 participants, and described aspects of a commitment to the profession of healthcare leadership. P2, P7, P10, and P11 discussed the importance of living in the patient's shoes to avoid overreliance on technology. P7 commented on medical professionals' beliefs that technology and big data will solve all the big problems. P2 stated, "I wish you would go through the process as a patient and as a physician, live in the day of, before you make any decision." P10 stated that medical leaders were too involved with record keeping, EMRs, and quality of care that often kept patients out of the loop. P11 referred to the importance of not sacrificing personal and professional standards to appease the patient. Additional lessons were the focus on loving what you do in medicine and being dedicated to challenging work and excellence in practicing medicine.

Trust your patients. Five of the 12 participants emphasized the ability to trust the patient was a lesson to be shared with emerging healthcare leaders. Listening was a common theme discussed by P4, P7, and P9. Being empathetic, knowing what patients want, and achieving better communication could be realized by listening. "Something I learned as a clinician, is people will tell you what's wrong with them if you just take time to listen, and I think that's one of the things we don't always do as well as we could" (P7). There was also consensus that

patients tended to listen to their healthcare provider before they would listen to an insurance company or governmental agency.

Patient advocacy emerged as another recommendation for emerging healthcare leaders. In an environment of cost containment, it was important to be patient's advocate (P12) and that understanding patient care from the patient's perspective could provide healthcare leaders with a valuable set of understandings to help in the decision making (P8). Focus groups to understand what was relevant and what was expected by the patient in terms of outcomes or preferences was suggested as a method to build trust and advocacy.

Continue training. Three of the 12 participants recommended continued training for emerging healthcare leaders. P6 suggested to internal medicine residents not to stay in general medicine, but to pursue a specialty. He also recommended new physicians have an outpatient office-based practice to have their own population of patients. Finances may fluctuate year over year, but if you love something, you will always enjoy it (P6). Continued training was recommended by P1 and P3. P1 elaborated on nurse practitioners and physician assistants who practice general medicine. He did not believe their academic and clinical training prepared them for practice. He recommended that these mid-levels shadow him for two years before he hired them full time as a practitioner. P3 discussed loving your profession, considering declining financial gain for physicians.

Interview question 10. "What mistakes have you made and what lessons have you learned from?" Based on responses from the healthcare leadership experts, three themes were constructed. Common themes that were determined by the participants included practice of medicine, efficiencies of MCOs, and health insurance. Figure 12 shows the number of responses for each theme.

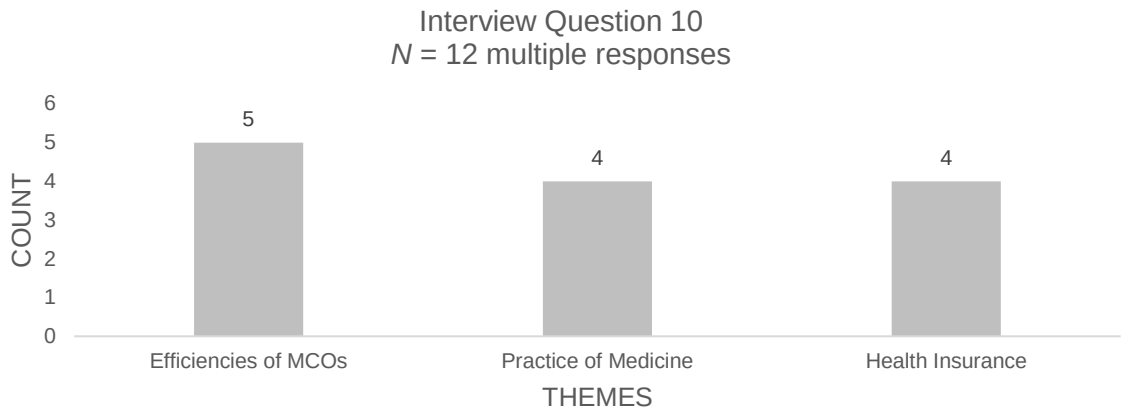

Figure 12. IQ10: Themes on mistakes made and lessons learned.

Efficiencies of MCOs. This theme surfaced with 5 of the 12 (42%) participants commenting on the failure of managed care organizations (MCOs). P5 stated when working with MCOs there was less hands-on with patients and more time with technology. There was also an over expectation on evidence-based medicine versus experience. P1 shared that the theory of MCOs was lovely, but they were ineffective in today's environment because there was less interaction between physicians, no caring environment, and no cost savings. P11 believed that managed care organizations have increased control over health care providers, while increasing their revenue. In addition, P11 commented that private insurance firms and for-profit organizations are decreasing provider revenue.

Practice of medicine. Four of the 12 participants conveyed key lessons on the practice of medicine. P1 indicated that he had made mistakes by being too trusting and being taken advantage of as a medical leader. P2 commented that the practice of medicine has become more difficult over time, contrary to what he believed. P3's significant lesson was a result of the excellent pathophysiology training she received in medical school: "It upsets me that in the medical community, the residents and the medical community are not learning how to think about why they're doing what they're doing." P4 shared that he was trained to use a paternalistic

style to guide, inform, and make recommendations to the patient. He learned over time that people can make their own decisions if they understand the choices and consequences.

***Health insurance*.** Four of the 12 participants shared key learnings on health insurance in the U.S. P2 indicated the insurance companies were challenging to learn. He felt an inability to help people due to the navigation of health coverage. P1 supported the development of a single payer in the U.S but felt it would not happen with the financial incentives and profits of commercial insurance companies. P10 noted her patients complained that the insurance companies infringed upon them and intervened on the relationship with patients. P10 had learned to not forget the patient in the process. P12's lesson was that with the costs of healthcare insurance, medical leaders must remain advocates for the patients.

Interview question 11. "What systemic recommendations will you implement to improve outcomes?" Based on responses from the healthcare leaders, three common themes were identified: improve access to care, identify problems, and improve outcomes. Figure 13 presents the number of responses for each theme.

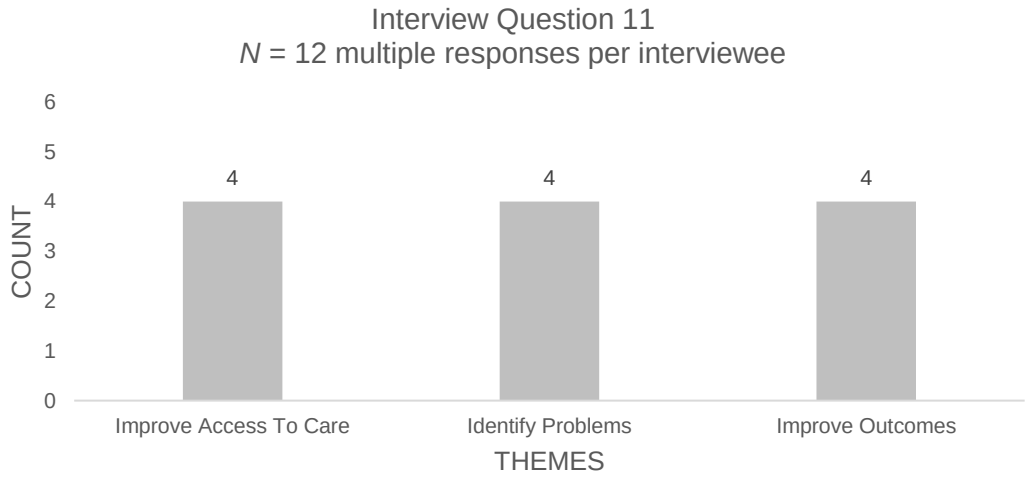

Figure 13. IQ11: Themes on systemic recommendations to improve outcomes.

***Improve access to care*.** Four of the 12 participants provided insight into the systemic recommendation to improve access to care. P2 referenced the pharmaceutical industry's use of pharmacy benefit managers who acted as middlemen in the negotiation of drug prices. P2's recommendation was to get rid of the middlemen who rip off patients. P6 provided insight into the universal care single payer health plan; he would not recommend universal care for the U.S. P9 recommended new medical graduates work in small cities and rural communities where access to care was limited.

***Identify problems*.** Four of the 12 (33%) participants shared their perspective on the systemic recommendation they used to identify problems. P4 and P10 recommended the implementation of coordinated care teams to uncover potential barriers to access care, address social determinants of health, or impending challenges. Teamwork between the specialty physicians and nursing staff was helpful (P10). P7 addressed the need to quantitatively and qualitatively analyze data to identify issues and then build programs that would address the issues or provide solutions.

***Improve outcomes*.** Four of the 12 participants provided perspective on improved outcomes as a recommendation for systemic changes. The standard to follow treatment protocols was mentioned by four of the participants. P3 stated the mandate to follow protocols took the experience and training of the physician out of the picture. P8 suggested incentivizing healthcare providers to discover solutions to reduce hospitalizations and provide better service. P10 suggested better communication among primary care, specialists, and nursing staff for patients would provide better outcomes. P11 referred to physician remuneration and suggested that if physicians were paid well, they would not have to worry about the cost of malpractice insurance, would practice better medicine, and would not worry about their revenue. In addition, P12

supported patient engagement through education, involvement in the EMR system, and accountability. These behaviors from the patient would achieve better outcomes (P12).

Research question 4 summary. Research Question 4 asked, "What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes." This research question included the following interview questions to derive responses from the participants:

- IQ8: What recommendations can be implemented to provide solutions to improve outcomes?
- IQ9: What lessons will you share with emerging healthcare leaders?
- IQ10: What mistakes have you made and what lessons have you learned from?
- IQ11: What systemic recommendations will you implement to improve outcomes?

Research Question 4 sought to gain insight into what recommendations the healthcare leaders would implement to provide solutions to improve outcomes. In IQ8 the themes of access, reimbursement, and social determinants were discussed as areas of note for the emerging healthcare leaders. In IQ9 the themes of dedication to profession, trust your patient, and continued training addressed the question on lessons the healthcare leaders would share with emerging leaders. In IQ10, the participants identified mistakes made and lessons learned. The themes revealed were efficiencies of MCOs, practice of medicine, and health insurance issues. In IQ11, the healthcare leaders were asked what systemic recommendations could be implemented to improve outcomes. The themes that emerged were improved access to care, problem identification, and improve outcomes. Table 10 provides a summary of the 12 themes developed in the final research question.

Table 10

Summary of Themes for Research Question 4

IQ8: Recommendations to provide solutions to improve outcomes	IQ9: Lessons shared with emerging leaders	IQ10: Mistakes made and lessons learned	IQ11: Systemic recommendations to improve outcomes
Reimbursement	Dedication to profession	Efficiencies of MCOs	Improve access to care
Access to healthcare	Trust your patients	Practice of medicine	Identify problems
Social determinants	Continued training	Health insurance	Improve outcomes

Chapter 1 included the statement of the problem, purpose statement, background, significance, and definition of terms. Also included were the assumptions of the study and the limitations. Chapter 2 examined all current literature about leadership strategies in healthcare and influences of health outcomes. Chapter 3 previewed the strengths and weaknesses of the study, nature of the study, methodology, sampling, design, purposive sampling population and protection of participants. Chapter 4 detailed the data collection and coding process and the themes related to interview questions. Chapter 5 summarizes the key findings, implications of the study, and recommendations for future research.

Chapter 5: Conclusions and Recommendations

Healthcare is one industry where little is known about how prepared leaders are in their awareness or competencies in solving the priorities in care. Thus, health care delivery, health disparities, barriers in access, health care outcomes, and the role of leaders all contribute to today's healthcare challenges impacting patients, medical providers, and healthcare leaders. Furthermore, the disparities in health are increasing, and the financial strain of major illnesses are creating an undue burden on families and their communities. This research study contributes to the literature on leadership strategies to address healthcare outcomes. Additionally, this body of literature will serve as a resource to healthcare leaders, managed care organizations, medical institutions, and medical practitioners in developing sound strategies that will influence health outcomes.

In Chapter 5, the researcher's analysis of the data collection and literature are summarized. The remaining sections of this chapter review the highlights of research findings from the study with reference to the literature. Implications of the research, recommendations for future research, and concluding thoughts are included.

Summary of the Study

This research study used a phenomenological approach to explore the impact to diverse populations and provide insight on the strategies to improve health outcomes. The research focused on the areas of identifying leadership challenges in treatment, disparities, and measures of success. In addition, the types of disparities confronting healthcare leaders were identified and employed a phenomenological approach to explore its impact on diverse populations, providing insight on the models that will impact change. The research questions are outlined below:

RQ1: What are the challenges you face regarding influencing healthcare outcomes?

RQ2: What current strategies do you use to address these challenges and barriers?

RQ3: How do you measure and track your success with overcoming challenges and barriers?

RQ4: What recommendations would healthcare leaders provide to aspiring leaders in healthcare to improve outcomes?

The research study comprised five chapters: Chapter 1 introduced the topic of research and structure of the research, Chapter 2 introduced the literature on leadership strategies to improve health outcomes, Chapter 3 framed the methodology; and Chapters 4 and 5 presented the data analysis, coding, summary, and recommendations.

Summary of the Findings

The findings are a result of the data analysis derived from the 12 participants' semi-structured interviews. The 12 participants in the research study were healthcare leaders and included 8 males (67%) and 4 females (33%). The 12 participants held healthcare leadership positions as medical director (2 participants), chief medical officer (2 participants), health plan director (1 participant), medical group owner (3 participants), hospital director (1 participant), and private practitioner (2 participants).

Using a multi-stage clustering procedure, the healthcare leaders were recruited from a master list using the Healthcare Inc. organization as the source. Then, following the first stage, the researcher obtained the names of healthcare leaders within the groups, and selected samples from the cluster. Participants who had at least two years of experience as a healthcare leader in the Healthcare Inc. list of top CEOs were selected from the continental U.S. Additional segmentation narrowed the population to additional inclusion criteria of health-related roles.

The study was conducted using 11 open-ended questions and follow-up questions during the interviews of the 12 participants. Interviews were conducted either face-to-face, through video conference, or phone calls. Listed below are themes from each interview question that identified leadership strategies to improve healthcare outcomes:

- The careers of the healthcare leaders were diverse. They all had over 2 years' experience and averaged 20 years tenure. All participants, except P8 (director of medical technology) had a designation and experience as a medical doctor. All participants had patient facing roles during their career as a health care leader.
- Insurance, delivery of care, and social determinants were themes healthcare leaders identified as challenges faced that influence healthcare.
- Cultural competencies, social determinants of health, and insurance issues were among the common themes on cultural barriers faced with diverse communities.
- Patient focus, patient outreach, and economics were the common themes identified as strategies used to incorporate the strengths of leadership to influence health outcomes.
- Community outreach, eliminate bias, and communication were strategies used by healthcare leaders to address cultural barriers.
- Patient care, economic indicators, and follow-up were the themes describing how healthcare leaders measure and track success in health outcomes.
- The use of tailored programs, quality measures, and treatment of patients were themes describing the resources used by leaders to measure and track cultural barriers and diversity.
- Reimbursement, access to care, and social determinants were themes identified where solutions could be applied to improve outcomes.

- The healthcare leaders detailed that dedication to profession, continued training, and trusting the patient were lessons learned that should be shared with emerging healthcare leaders.
- None of the 12 participants responded to mistakes made. They did frame their response to lessons learned. These themes included inefficiency of managed care organizations, holistic practice of medicine, and their feelings about health insurance.
- Systemic recommendations included themes on improved access to care, identification of health problems, and improvement of health outcomes.

Discussion of Key Findings

The key findings from this research will provide additional insight and awareness of the challenges, strategies, and recommendations for healthcare leaders to impact health outcomes. The key findings are compared to the literature in Chapter 2 and to the data derived from the 12 participants.

RQ1: Challenges faced by healthcare leaders to address issues on patient outcomes.

A goal within the healthcare industry is to improve outcomes while reducing costs. Recent literature and research have illuminated various factors that contribute to worsening health outcomes and increased costs. Factors impacting providers of health care and patients alike include the delivery of care, social determinants, cultural competencies, and insurance. These concerns contribute to discourse on cost burden, access to care, and their role in achieving quality objectives (Copeland, 2005; see Figure 14).

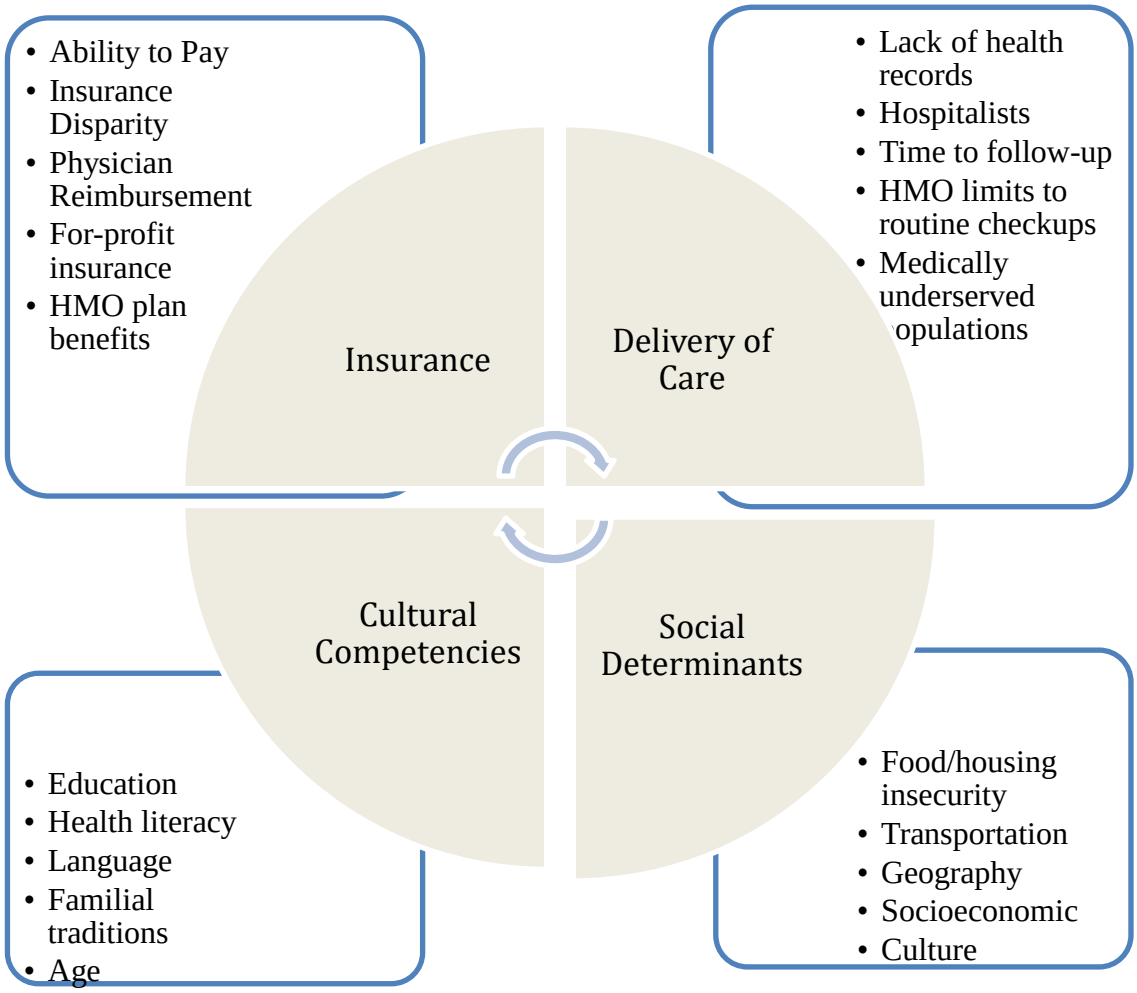

Figure 14. Challenges faced by healthcare leaders to address issues on patient outcomes.

One of the themes identified by participants as challenges faced by healthcare leaders in addressing outcomes was insurance. Insurance challenges impact the patients as well as the medical providers. Issues within insurance included the patient's ability to pay, physician reimbursement, and access to affordable insurance. Another facet of insurance was the reimbursement to medical providers. Participants conveyed that reimbursement and access were directly related to physician reimbursement and patient health plan benefits that were unequally distributed to the wealthy (P1, P2). The responses of P1 and P2 were underscored by sentiments of not being able to care for patients equally.

Listening to the narratives of the participants, correlations were drawn from the literature reviewed in Chapter 2 on barriers to care impacting health outcomes. A prominent barrier in care is the lack of health insurance due to the lack of resources for minorities to purchase insurance (Kimbrough-Melton, 2013). According to the Kaiser Family Foundation, Hispanics are three times more likely than Caucasians to not have insurance. Compared to 13% of Caucasian Americans, 27% of Native Indians, 21% of African Americans, and 18% of Asian Americans have health insurance (Kimbrough-Melton, 2013). Compared to Caucasians, 70% of African Americans, 79% of Latinos, and 70% of American Indians are in low wage, blue collar employment and lack employer-funded health insurance (Kimbrough-Melton, 2013). P12 commented, "the most frustrating to me is if I have a situation that I know something will help a patient and I can't get it approved and the patient has to suffer."

Delivery of care was another theme identified as a challenge faced by healthcare leaders impacting patient outcomes. Delivery of care has a significant role in addressing healthcare outcomes. Descriptors of delivery of care included socialized medicine guidelines, medically underserved populations, time to follow up, technology, hospitalists, and equality of care. Health records emerged as a topic among participants. The lack of health records for underserved populations presented a significant challenge. Based on literature in Chapter 2 on the health system infrastructure, health IT/EMR electronic medical records are structural elements that may affect quality improvement. Participants shared that inadequacies in the health infrastructure may contribute to quality of care and poorer outcomes in disparate populations. Health IT may effectively manage costs and impact quality of care.

Another theme expressed as a challenge faced by healthcare leaders was that defined as social determinants of health. The social determinants of health emerged across several research

questions. As pertaining to patient outcomes, the determinants included patient lifestyle, demographics, poverty, family/culture, language, health literacy, and transportation. Social determinants of health often determined whether patients were going to be successful in achieving outcomes. P4, P5, and P8 discussed the importance of addressing the social determinants prior to treating disease. Language also was presented as a cultural barrier. P10 and P6 referred to language as a barrier for the provider and the patient. P7 commented on health literacy and healthcare education as factors that could improve health equity. Identifying the proximate causes of a problem and root causes where patients were not compliant to their prescribed regimen was the nexus for addressing the social determinants. An example shared by P8 was a patient who needed to care for his or her diabetes and it was discovered here was housing or food insecurity. In addition, the patient's support system of family, culture, access to food could help a patient's desire to be compliant (P5, P4, P8).

Patient education was another challenge identified in influencing healthcare outcomes. Health literacy and the patient's education level were noted as challenges. Participants stressed the correlation of patient education and outcomes. Caregivers must overcome patient's literacy and comprehension of disease and treatment and to provide basic education that would make patients more compliant. The challenge to healthcare leaders was the time it takes to follow up and provide the necessary education.

Five of the 12 participants indicated that cultural competency was a barrier in diverse communities. Interestingly, this was viewed from two perspectives. P7 addressed how cultural confidence was needed for health equity for factors such as healthcare education and health literacy. Cultures and traditions of families can be barriers to care. P12 stated the cultural barriers he faced with patients were due to the level of education, perception, and age of the patient. Age,

religion, cultural influences, and family played a significant role in patient's trust and compliance. Religious beliefs can change the outcome and treatment options (P6) and familial influence in not trusting health leaders.

RQ2: Current strategies and practices employed by healthcare leaders to influence outcomes. When considering the factors that influence health, health leaders can view options thru the lens of opportunity and value rather than cost drivers. Current strategies employed by healthcare leaders often look to community partners, stakeholders, and methods to meet that patients where they are. Research Question 2 was designed to understand the strategies and practices implemented by participants to address health outcomes. The top themes and practices employed by healthcare leaders were communication, patient focus, community outreach, and economics. In IQ4, communication was frequently cited as a leadership strategy that influenced patient outcomes (P4, P5, P7, P12). Participants found value in meeting with patients face-to-face rather than telephone calls to learn about the patient and influence their behaviors (see Figure 15).

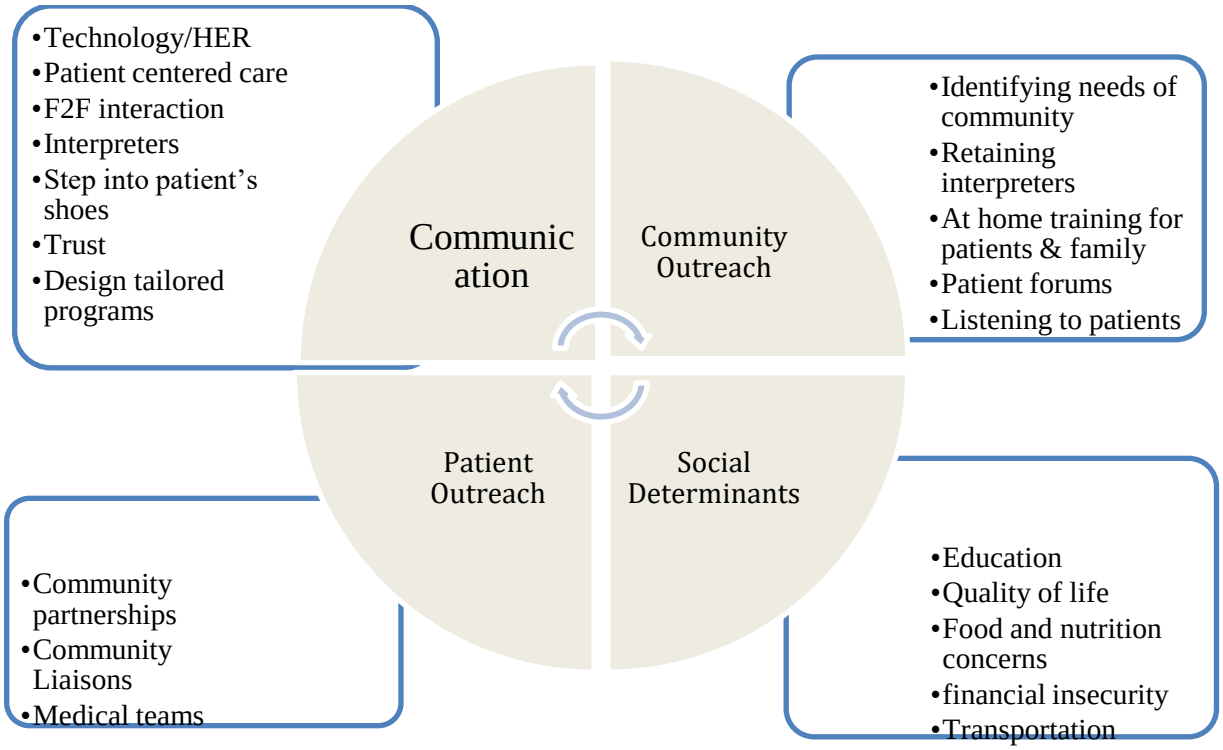

Figure 15. Current strategies and practices employed by healthcare leaders to influence outcomes.

The use of well-trained interpreters also was a strength to make patients comfortable and to ensure all communication was understood between healthcare provider and patient. The use of electronic medical records allowed the patient's care team to communicate updates on the patient and consult on treatment and follow-up.

In RQ2, 41% of participants indicated that community outreach was vital in addressing cultural barriers and influencing health outcomes (P4, P5, P6, P7, P8). Community outreach with community health partners and social services served as a resource. Partnerships with community organizations that patients trust were important to be successful (P7). The participants discussed outreach examples of identifying the needs of the community and what resources were available in a community, retention of interpreters to represent the demographic makeup of the community, providing at home training and education for patients and family

members for chronic diseases like chronic kidney disease and dialysis, and visiting inner-city clinics to observe challenges.

In addition, incorporating economics into strategies and practices was essential for healthcare leaders to influence healthcare outcomes. Economic factors included corporate savings, costs, utilization of services and resources, and reduced hospital admissions and re-admissions. From a corporate perspective, healthcare leaders measured outcomes in terms of savings (P7). When improving disease outcomes, the prevention of patient readmissions into the hospital or increased ER visits, or fewer days in the hospital was achieved (P7). These types of savings can be measured and strategized. Also, participants commented on recognizing epidemiology of disease in specific patient populations. When costs in certain populations are increasing, it may be possible to identify that in specific populations, like HIV, costs may be three to four times higher than your baseline population.

Economics also impacted the healthcare leader's incentive structure. Based on the literature in Chapter 2, increased attention has been focused on incentivizing healthcare providers to reduce disparities in ethnic and racial populations by instituting pay for performance (P4P) incentives. Payers and policymakers reward quality of care to hospitals and clinicians who disproportionately care for minority patients (Weinick et al., 2010). P4P included the objective of improving the cultural competence of providers. Racial and ethnic disparities were noted in areas where P4P initiatives in chronic diseases were common, such as diabetes and myocardial infarction (Weinick et al., 2010).

RQ3: How successful healthcare outcomes are defined, measured, and tracked.

Economic and performance outcomes measure the quality and effectiveness of parameters on the healthcare received by patients. Agreements are broad in determining the

effort and practices in measuring economic output. The data points are imperfect, but health providers have a lens into the amount of spend in aggregate for physicians, hospitals, medication, and other services; and how it all is changing overtime. Statistics indicate the U.S. spends more on health than any other country per person and share of the economy (see Figure 16).

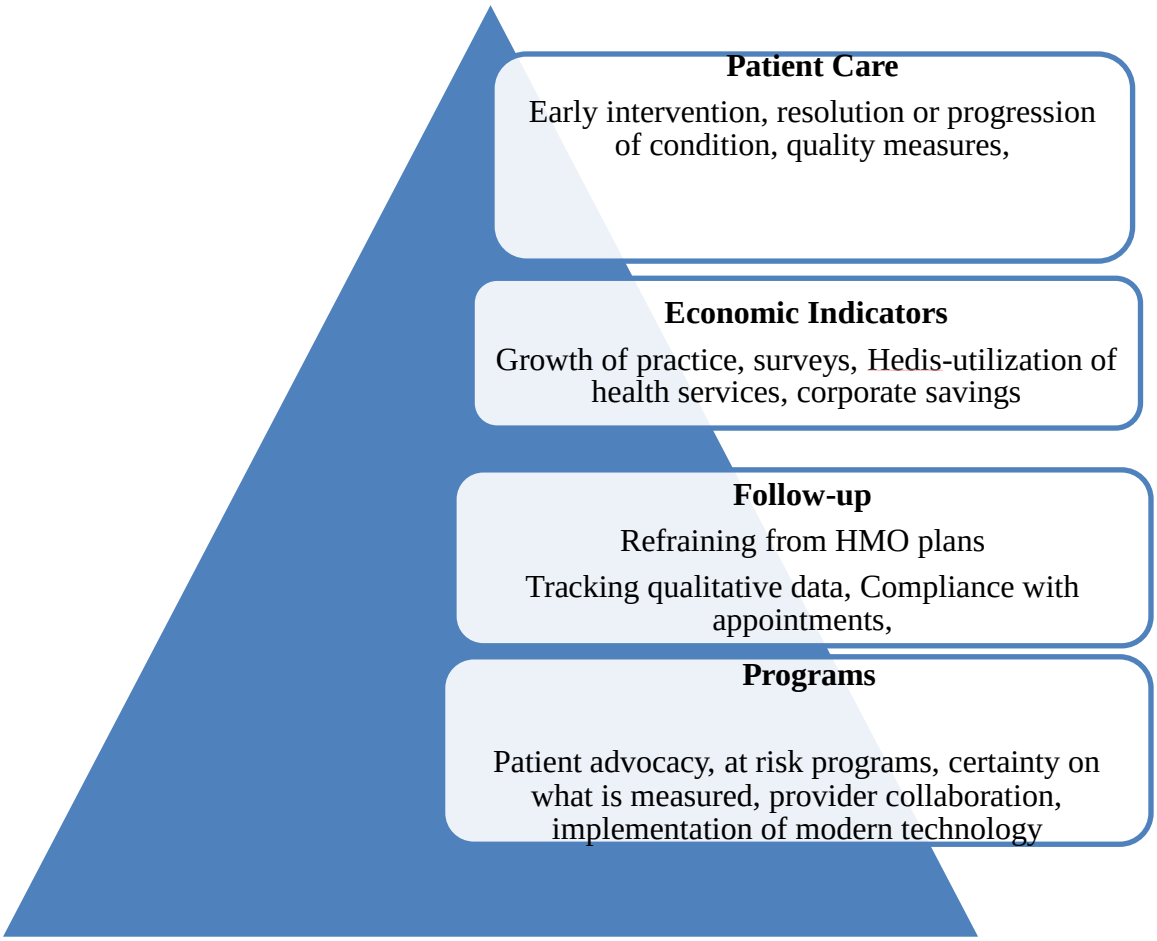

Figure 16. How successful healthcare outcomes are defined, measured, and tracked.

Research Question 3 was designed to gain insight on the process used by healthcare leaders to measure and track outcomes. IQ6 and IQ7 were designed to identify how health measures were designed to measure and track outcomes and cultural barriers and diversity. Themes that cultivated discussion included quality measures, treatment, programs, economic indicators, and patient care. In IQ6, the participants identified economic indicators and patient

care as tools to measure outcomes (P3, P4, P7, P8). The growth of a medical practice or organization and volume of patients was interpreted as generating successful outcomes for patients (P3). In a corporate leadership setting, outcomes were measured and tracked by costs. In healthcare corporations, outcomes were defined and measured through the quality of managed care and service performance. These measures were evaluated by Healthcare Effectiveness Data and Information Set (HEDIS, P7, P8), which evaluated costs on the utilization of health services as indicators as to outcomes and cost savings. Diagnoses and treatments were coded and tracked. P1 and P12 discussed the importance of careful and accurate diagnosis, not only for HEDIS measures, but for early interventions to prevent the advancement of disease and success in treatment. Resolution and progression of medical condition was cited by P7 and P6 as ways they track and measure outcomes. Early intervention was a common theme across all three participants. Although they had not conducted scientific studies for their diverse populations, they did indicate that early detection and intervention avoided poor outcomes.

Four of the 12 participants commented on quality measures, treatment, and programs that impacted patient care. These measures were also effective in measuring and tracking cultural barriers and diversity. Several factors of patient care were instrumental in measuring and tracking success in health outcomes (P1, P6, P7, P12). Three out of 12 (25%) participants referenced quality measures used in tracking and measuring cultural barriers and diversity. Adherence to treatment and compliance with healthcare provider instructions could be measured with quality metrics. Quality metrics were used to evaluate outcomes in terms of costs in reducing ER visits, readmissions, and patient education (P7).

The creation of programs to address a patient's health literacy, socioeconomic status, education, and treatment were commonly used to evaluate outcomes. Community partnerships

with patient advocacy programs targeted at-risk patients. These programs have success rates in improving patients' targets and goals and enhancing their disease state knowledge, thus improving outcomes. What was emphasized by healthcare leaders was the need to isolate the problem you are looking for and what you are trying to accomplish or learn when creating targeted programs.

RQ4: Recommendations to aspiring leaders to improve outcomes. With the current health industry's shift to drive value-based outcomes, health care organizations and leaders have a strong focus on improving healthcare outcomes. Among the benefits of these priorities are early detection and prevention, improved access for patients, development of aligned care teams, action to address social determinants, and adherence to treatment guidelines. Processes and action to address these priorities lend to improved financial, clinical, and patient engagement outcomes. Financial outcomes including healthcare revenue, expenditures, patient spend, and physician remuneration were key insights derived from health leaders in this research.

It was recommended that better treatment, improving access to affordable healthcare and early detection of chronic disease saves healthcare dollars while improving patient conditions. The topic of physician payments and reimbursement from health plans and government agencies can negatively influence outcomes. Additionally, the reduction in payments to providers and coverage of medical procedures retract from the quality of care and adherence to treatment guidelines. Although patient care is the ultimate priority, health leaders also must afford stay in business and cover their expenses (see Figure 17).

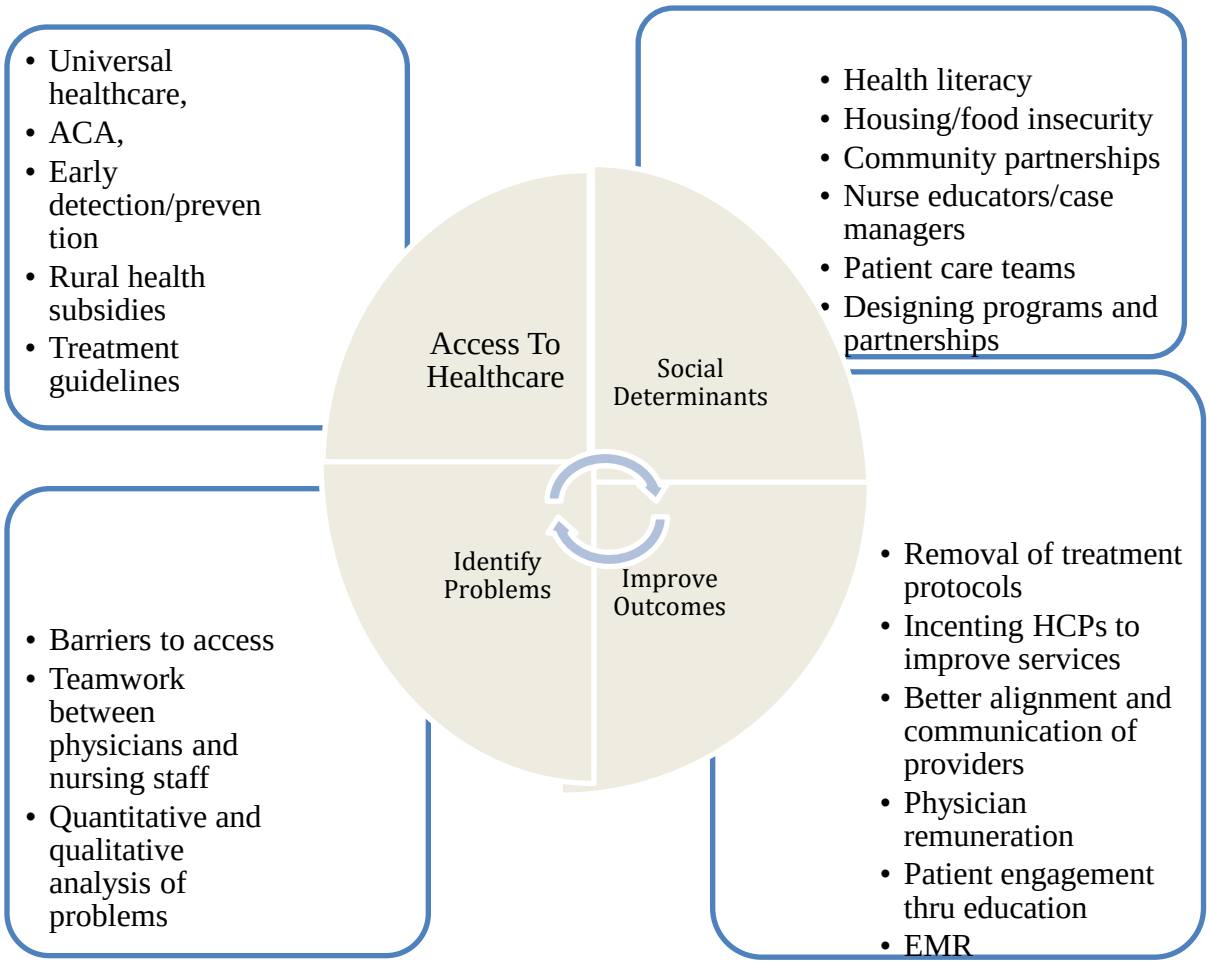

Figure 17. Recommendations to aspiring leaders to improve outcomes.

A recommendation to aspiring leaders was to challenge the practice of withholds and bonuses for keeping costs low for patient care. The practice of incentivizing physicians for saving money was described as perverse by P1 and P11. Five out of 12 (42%) participants indicated that solutions to improve reimbursement can be implemented to improve outcomes (P1, P5, P8, P9, P11). They commented that they get money back at the end of the year from insurance plans and medical groups for saving money. All respondents indicated that improving access to healthcare provides three core benefits to all: early detection, prevention, and advances in treatment guideline protocols designed to drive positive outcomes.

Additional lessons were the focus on loving what you do in medicine and being dedicated to challenging work and excellence in practicing medicine. There was a common theme of over reliance on technology, rather than practicing the pure art of medicine and pathophysiology. Listening to patients, patient advocacy, and knowing what the patient desires for outcomes was noted as lessons that would impact emerging leaders. There was also consensus that patients tend to listen to their healthcare provider before they would listen to an insurance company or governmental agency. In an environment of cost containment, it was important to be patient's advocate (P12) and that understanding patient care from the patient's perspective can provide healthcare leaders with a valuable knowledge that could assist in decision making (P8).

Social Determinants of Health

Current discourse in the U.S in health policy and health laws argue if healthcare is a right or a privilege for citizens. This was the impetus for the Affordable Care Act (ACA) which was designed to expand access to healthcare for more of the population, expansion of Medicaid, and state affordable ACA health plans. The result was an increase in health equity. Health equity is realized when individuals have the resources and ability to attain their full health potential. When health equity is achieved, it removes one from being disadvantaged due to social or financial status or any other circumstance. Without equity in healthcare, numerous economic, health and social consequences may emerge that negatively affect health organization, patients, and their communities. Healthcare impacts and plays a role to the issue health equity problem in many ways, including lack of awareness of patient's living condition, financial means, cultural norms, language and literacy barriers, as well as clinical bias. These factors are referred to as social determinants of health. Ignorance or lack of attention on the importance of social determinants of health contributes to health disparities, health iniquities and poor treatment outcomes.

Healthcare providers diligently work to identify relevant information on their patients in a relatively short span of time. For most patients, these brief chats are primarily suited to address low-risk health conditions. However, for those suffering with chronic conditions, episodic intervention to care is insufficient to meet and address approach to treatment. In the four research questions presented in this study, the topic of social determinants of health was raised. The factors of social determinates including food and housing insecurity, health literacy, community partnerships, transportation, geographic location, and education all contribute to health outcomes. Per the participant's observations, these environmental factors and their toll on chronic illness, greatly influence a patient's health outcome and the utilization of available health resources to address patient's medical and social needs. With respect to food insecurity, patients and their caregivers need to have stable access to healthy food choices to achieve proper nutrition. It was indicated by the research participants that availability of fruits and vegetables and protein sources in food deserts and in underserved communities are non-existent. In addition, stable housing and affordability to pay utilities often leave patients without shelter or access to proper storage of fresh foods. Also noted were the rates of high hospitalizations and emergency room services attributed to these populations.

There was significant discussion among healthcare leaders on the proper intervention and resources to address the social determinants of health to deter potential long-term negative health outcomes. Health organizations, insurance plans and health providers invest in data analytics to analyze trends and costs. Electronic medical records and predictive analytics may play a role in determining health trends and cost containment tools. However, the analytics are not often as useful to facilitate conversation and personal connection. In addition, many health leaders in this research indicated the importance of building trust and developing community relationships with

their patients to individualize treatment and approach to care. One tool to incorporate is a health inventory that would allow physicians and care teams to provide early intervention and understand patient's needs upon initiating care. Upon intake, a health provider can institute the inventory to gain insight on immediate patients' needs and gaps in living. Once needs are identified, the healthcare providers, institutions and begin community and health resource partnering to assist with food, housing, utilities, education, or literacy concerns. This resource may begin to allow health providers to reach beyond the perimeters of the medical office, clinic or hospital and connect to patients where they live, work, worship, shop, and in schools (see Figure 18).

Social Determinants of Health Inventory

Housing

1. What is your housing arrangement?
2. Do you have a regular place to live (hotel, shelter, street, friends, car, park)?
3. Do you have problems with non-working appliances?
4. Do you have pests in your home?
5. Do you have working water and heat?

Meals

1. How often do you have meals daily?
2. Do you live close to a grocery store? What is the distance from your home?
3. Do you regularly have fruit or vegetables? How often?
4. Do you have fish, chicken weekly? If not, how often?
5. In the past 12 months how often did your food supply decrease before you had more money?

Daily Living Needs

1. Do you have reliable transportation?
2. Has transportation kept you from seeking medical attention or employment?
3. How often do family or friends mistreat or abuse you?
4. Do you seek medical attention or have a physician?
5. Do you have health insurance or public assistance?

Figure 18. Social determinants of health inventory.

Note. Adapted from "Using Standardized Social Determinants of Health Screening Questions to Identify and Assist Patients with Unmet Health-related Resource Needs in North Carolina" by the North Carolina Department of Health and Human Services, 2018, p.1-21.

Systemic recommendations to improve healthcare included recommendations to improve access to care for medical care and pharmaceutical drug prices. Participants shared their perspective about the systemic recommendation to identify problems with the use of coordinated care teams to uncover potential barriers to access care, address social determinants of health, or impending challenges. Respondents shared how they and their respective health organizations are seeking community-based partnerships to deliver targeted programs, food delivery, familial and culturally based health education, and shared transportation to engender proactive approaches to care. Clinical results have driven a reduction in risks, reduction in need for expensive acute services, more efficient utilization of health resources, and better control of chronic conditions. Although, in addition, the need to quantitatively and qualitatively analyze data to identify issues and development of targeted programs to provide solutions was emphasized. The more we can accomplish at a local level to overcome the cultural divide among the provider and the patient, we are able to address the dived in treatment, diagnosis, intervention and outcomes.

HealthCare Transformation Model

The healthcare system is in vital need of transformation for healthcare leaders to impact health outcomes. As the healthcare environment is undergoing challenges in access, patient care, disparities, and economic challenges, the need for rapid intervention is a priority. According to Kotter (1996), successful organizations will emerge to address the rapid pace and competitive environments with a new type of employee. Successful leaders develop the competency to lead in complex and transitional environments and grow in their capacity for advancing transformation (Kotter, 1996). The acceleration of advancement in the healthcare industry calls

for leaders to adapt to the change and foster innovation in research, diagnostics, devices, and therapies.

Recently, healthcare innovation focused on the creation of new procedures, types of therapy, medication, or medical equipment. These innovations include novel large and small molecule pharmaceutical agents and more precise medical procedures and diagnostic tools designed for prevention, detection, and eradication. As these innovations have produced remarkable results, there is resistance and inconsistency in how health care leaders' model transformative leadership as well as operationalize innovation across their organizations.

The rapid acceleration in medical research has engineered exponential change and opened the doors to in health policy, community partnership, health education, improvement in diagnosing and assessment, and resources in health monitoring. Thus, to create alignment and consistency in approaches to care, a Healthcare Transformation Model can provide the roadmap for healthcare leaders to improve healthcare outcomes. The Healthcare Transformation Model proposes three major healthcare priorities identified in this research and recommended solutions incorporating care models, tailored care, comprehensive partnerships, current research and policy, and options for effective patient encounters.

The seven components of the Healthcare Transformation Model to influence health outcomes are as follows (see Figure 19):

Research. Healthcare outcomes are dependent on the collaboration and interaction between the health leaders, patients, and the health system. All work together to navigate the complex components of care. The advances in medical procedures, pharmaceuticals, equipment, and innovative approaches to care are derived from research. Research in health policy, patient participation in studies, treatment, play a pivotal role in influencing outcomes, quality of life and

survival. Thus, research influences all aspects of healthcare and serves as the foundation to transform and impact health outcomes.

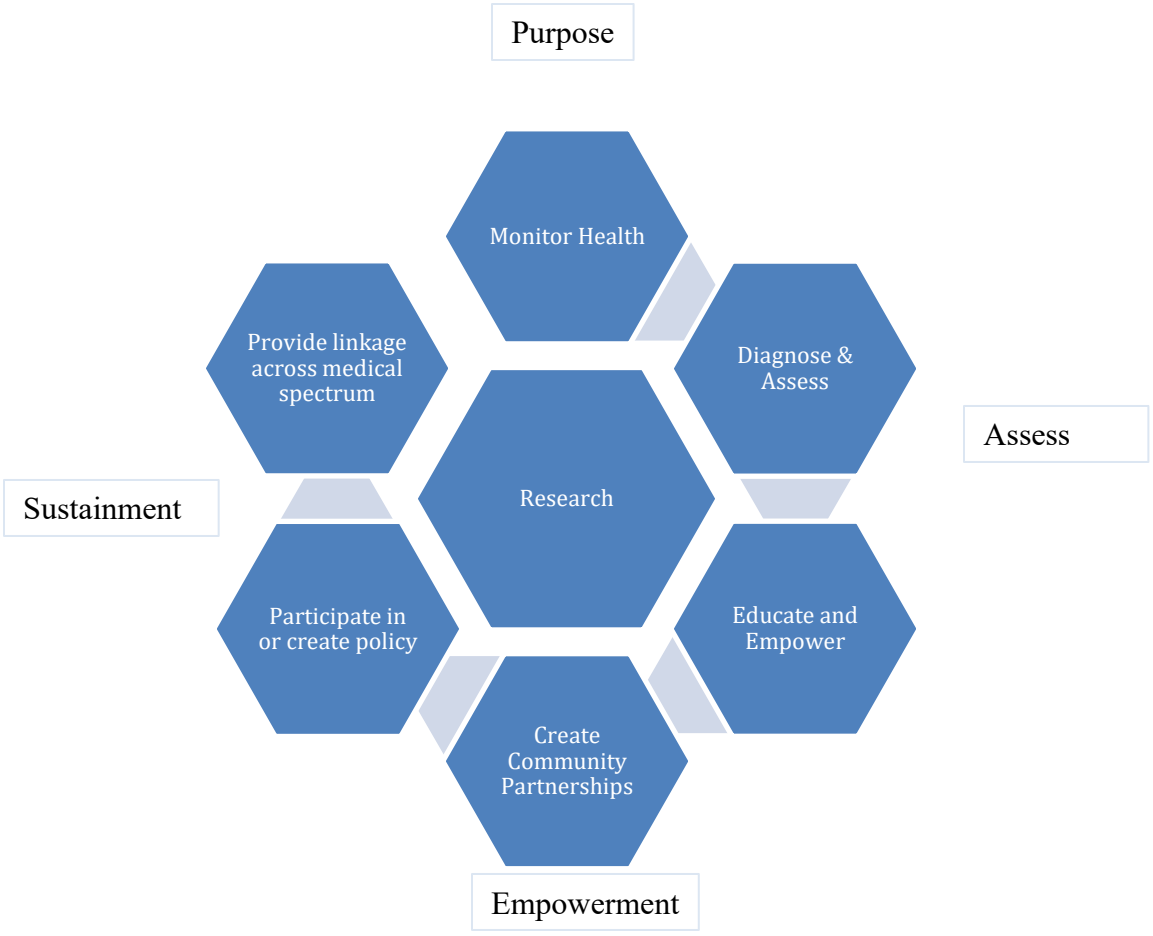

Figure 19. Healthcare transformation model.

Diagnosis and assessment. Whether confronted with patient health concerns or opportunities and challenges in the health system diagnosis and assessing has critical implications for research, patient care, and policy. Diagnosis is a form of classification process or established set of categories used by medical professionals to define a medical condition. It is equally used to specify and assess needs in healthcare prior to determining an approach or solution. Accurate and timely assessments and diagnosis by healthcare leaders influences positive outcomes, clinical decisions, resources, and coordinated care in meeting the needs of patients.

Educate and empower. Health education or health literacy is a priority among health providers in addressing health disparities by creating a foundation of care built on prevention and overall wellness. The correlation between health literacy and health disparities are driven by linguistic and cultural differences impacting patient's health literacy levels, which, in turn, contributes to an increased prevalence of health disparities. This particularly effects the elderly, racial minorities, immigrants, low-income, and non-English speaking individuals. As health providers are empowered to promote health literacy, they are also bridging a gap by learning the culture and norms of their patients. Providing medical information and helping patients to understand and implement healthy habits, the improvement in patient centered care promotes positive health outcomes.

Monitor health. Health information technology, in the form of electronic medical records, enables health care leaders to partner eliminate gaps in care and patient information. Sharing medical information expeditiously and effectively is believed to improve health outcomes, protect patient safety, and reduce medical errors. Additionally, health information exchange systems could play a role in strengthening care coordination and improving patient health outcomes, also allowing health providers track and monitor the delivery of healthcare.

Community partnerships. Cross-sector partnerships are valuable collaborations in improving a community's care coordination, health challenges, and addressing patient needs. Collaborative efforts are supported by traditional health systems as well as non-traditional community partners, as both are targeting and treating the same populations. The approach allows health leaders to align resources, tailor programs based on a specific need or population, optimize economic resources, operationalize programs, and reduce silos. Examples of community partners are schools, faith-based organizations, housing and transportation agencies,

churches, grocery stores, food banks, and community health clinics. Ultimately, the objectives established, and partnerships created will improve the health status and well-being of the community and its patients.

Creation of health policy. Health policies are created affect various facets of health care typically to impact outcomes by improving health equity, access to healthcare, and quality. Health policies also extends to broader aspects of the healthcare system to address governance, payer/insurance systems, disease outbreaks, mortality rates, or healthcare delivery. There is also discourse and calls for reform on social policies impacting social service expenditures, housing, education, and unemployment, and their impact on health outcomes.

Linkages across medical spectrum. The purpose of providing linkages across the medical spectrum is to improve the care coordination, resourcing, quality, and patient-centered care. When medical systems and providers work synergistically, they can improve patient care and provide support more efficiently and effectively than either could achieve independently. Coordinated health systems and medical practices reorient the delivery of healthcare and create a culture of health where services and providers of care are trusted and respond to the needs of the individual. The links extend to assets within the community where partners such as community services, organizations, can assist healthcare providers tailor resources to meet treatment goals can align available resources all designed to improve the health outcomes and quality of life.

Implications of Study

At the completion of the study, several significant findings resulted from the data. These implications have application to the study of healthcare outcomes and strategies used by healthcare leaders to address the challenges. The intent of this research study was to identify strategies and practices of successful healthcare leaders to improve access, identify disparities,

and evaluate methods to improve health outcomes. The lens into addressing the current and future challenges and issues in healthcare and strategies to improve outcomes is broad and will be the role of healthcare leaders to effect change. Based on the responses of the research participants, healthcare leaders must remain vocal in the importance in creating a need for change. As respondents shared, health disparities and their etiology differ from patient to patient. Thus, the importance of identifying the specific causes and issues surrounding health care disparities and outcomes is heightened. The need for change in how healthcare leaders and community partners is a call to increase awareness of the factors associated with social determinants of health that attribute to poor health outcomes. Partnerships between patients, caregivers, and providers can influence health literacy, cultural competence, quality and access, and policy and inclusivity at all levels in the healthcare process.

Recommendations for Future Research

Research in healthcare leadership in improving health outcomes is a broad and increasing studied body of work. The research is vast and expanding daily when addressing challenges, opportunities and solutions. The subject is continually transforming in policy, practice, and access. This the study concentrated on the scale, scope, and approach currently profiled by respondents and current research. The opportunity for future research is exciting. In addition, as a qualitative methodology study with healthcare leaders, common strategies may engender different results that also lends to various aspects of care. Suggestions for research include a study employing a mixed methods approach study to look at epidemiology and financial forecasting of disease. Costs of healthcare are rising and play a pivotal role in affordability for patients, health institutions, and insurers. All seek to improve health outcomes while controlling costs. There may also be value in stratifying disease outcomes across ethnic populations, income

levels, and age as studies and outcomes have results depicting a higher burden of care and negative outcomes among monitories and those in poverty. A retrospective study can incorporate quantitative analysis to evaluate chronic disease and treatment across a variety of factors contributing to variances in outcomes. With the adoption of the Affordable Care Act, a policy that influenced more access to care, expanded state Medicaid resources, and more patient's ability to obtain health insurance, health policy influence on care and outcomes has been written about and studied. A research focus on the health policy may open the door for new policy that may expand the positive outcomes for more Americans.

Final Thoughts

The inception of this research was to examine the existing state of healthcare and healthcare policy to determine its impact on supporting the healthcare needs of many with respect to cost, access, affordability, and outcomes. The current system and market support those who have the income and wealth to purchase quality insurance and afford preventative care. It was apparent that the costs for middle and working classes are staggering leaving many without insurance and access to care. The overwhelming and bi-partisan challenge for the U.S. in improving the current system of health coverage for its citizens is gaining consensus of the goal among policy makers. The current policies in healthcare have created the propaganda on the positions of healthcare being a right or privilege.

This study was powered to add to the body of knowledge concerning healthcare outcomes, access to care, and potential financial burdens for these treatment groups. The findings and recommendations will lead to a better understanding of the policy making process that governs access to healthcare from the perspectives of medical leadership and policy makers. In addition, the findings evaluate the issues confronting healthcare leaders in management,

treatment of chronic diseases that increase morbidity, comparing demographic trends, and evaluating future costs. It is the researcher's hope that the research will impact the improvement in healthcare disparities across populations, improvement in treatment outcomes, and provide insight on models to impact change throughout society.

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APPENDIX A

IRB Approval Notice

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: February 16, 2018

Protocol Investigator Name: Roxanne Smith

Protocol #: 17-10-653

Project Title: Leadership Strategies to Improve Healthcare Outcomes

School: Graduate School of Education and Psychology

Dear Roxanne Smith:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

APPENDIX B

Informed Consent Form

PEPPERDINE UNIVERSITY

(Graduate School of Education and Psychology)

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

(Leadership Strategies to Improve Healthcare Outcomes)

You are invited to participate in a research study conducted by Roxanne Smith and Farzin Madjdi, Ed.D at Pepperdine University, because I am conducting research on strategies to influence health outcomes. Your participation is voluntary. You should read the information below and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

PURPOSE OF THE STUDY

The purpose of the study is to identify leadership challenges in healthcare, identify strategies and practices of successful health care leaders to improve patient access, narrow the gap of health-related disparities, and evaluate techniques and methods to improve health outcomes across racial and ethnic groups. Moreover, this qualitative study intends to discover how the role of a healthcare leader can effect change in policy and medical management to meet the challenges identified. This study will explore questions that speak to the rapidly increasing change of the population, needs for healthcare leadership, and the disparate rate at which various populations address treatment issues and medical costs due to the progression of treatable diseases. The exploration of the leadership challenges in healthcare identified the current challenges faced by healthcare leaders in addressing issues in treatment, policy, and outcomes. The research also will identify current strategies and practices that are employed by leaders to influence outcomes. The research also may reveal success measures for healthcare leader's future recommendations. Additional insight will address access to healthcare for ethnic populations confronted with barriers to care and healthcare disparities.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to provide consent to participate in a semi-structured interview during a one-on-one interviewing process lasting approximately 60 minutes with 10-12 open ended questions that are designed in advance. A pre-designed interview guide will be used to conduct semi-structured interviews. Given that this study is exploratory and qualitative in nature; open-ended questions will be used to elicit the participant's insights,

feelings, beliefs and practices about leadership in healthcare. The survey instrument was developed and refined based upon feedback from a preliminary review panel and the dissertation committee. Data collection focused on the leadership effectiveness of authentic senior leaders at a large healthcare company. This data will be used to determine best practices and challenges in leadership and offer advice for future leaders. The data to be sourced to conduct this research will be based on a single variable. For this research, interviews will be conducted face-to-face or via internet through video conference (i.e. Skype), as needed and as a contingency approach. Through interviews and a review of literature, the researcher will be able to discover interrelationships, frameworks, and strategies contained in the phenomenon under review.

You can elect not to participate in the study at any time.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include possible risks that the participants might experience from their involvement in the study include: feeling uncomfortable with the interview questions or follow up inquiry; lack of interest or boredom; risk of breach of confidentiality; and fatigue for sitting for an extended period due to the interview.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society which include: Potential societal benefits may consist of practical identification of strategies for healthcare leaders to influence healthcare outcomes. The proposed research focuses on the areas of identifying leadership challenges in treatment, disparities, and measures of success. In addition, the research will identify types of disparities confronting healthcare leaders and will employ a phenomenological approach to explore the impact to diverse populations, medical practitioners, and health organizations, and provide insight on the models to impact change. Subjects may also gain awareness of strategies to impact their health organizations.

CONFIDENTIALITY

I will keep your records for this study confidential as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The data will be stored on a password protected computer in the principal investigators place of residence in the home office. The data will be stored for a minimum of three years. The data collected will be coded, de-identified, identifiable, transcribed etc. Confidentiality of participants will be maintained during the research process. To minimize risk and protect the identity of participants, pseudonyms and identifier codes will be used when reporting the results. The identity of the human subjects will only be known to the researcher. To minimize risk to

participants, they will be assigned a unique number and code, accessible only to the researcher, and personal identifiers were removed to protect confidentiality. There will be no identifiable data. Data will be obtained through a recording device was deleted after transcription. The audio recordings will be transferred from the researcher's laptop to a USB drive and stored in the locked file cabinet in the researcher's home office. The interview s may also be conducted via videoconferencing.

The researcher will take notes during the sessions. The protocol for the unique code will be a four-digit number that represents the month and day of the interview. If there are more than one interview for the day, a letter will be added following the four-digit code. For example, the first interview will be assigned 1101A, the second 1101B, etc. The key to the code and participant's personal descriptive information will be kept in a safe location and physical safe only known and accessible to the researcher for adherence to ethical considerations. In addition, printed and electronically recorded data will be secured to protect participant confidentiality, as well as research integrity. Skype addresses of participants will be removed from the researcher's contact list. The information collected and analyzed (e.g. recorded interviews, transcriptions, notes, and coding sheet) will only be available to the researcher and secured on a USB drive. Responses obtained thru the participant interview and association of the respondent will remain confidential. According to Pepperdine University IRB policy, all research related confidential documents will be destroyed three years after the conclusion of this research study.

To ensure anonymity and confidentiality, e-mail addresses and videoconferencing names will be removed from data. Participants will be assigned a code and will not use their names for videoconferencing access. All addresses and e-mail addresses with be deleted from the researcher's contact lists and removed from all data. All subjects need to be audio-recorded to ensure that the principal investigator is correctly capturing their responses. Recorded (written, audio, and video) information given by the participants will be stored in secured location for three years, and then will be destroyed after the three-year period.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact if I have any other questions about this research.

Roxanne Smith
Pepperdine University
Graduate School of Education and Psychology
Status: Doctoral Student
roxanne.smith@pepperdine.edu

Dr. Farzin Madjidi
Dissertation Chair
Associate Dean, Graduate School of Education and Psychology
Pepperdine University
farzin.madjidi@pepperdine.edu

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

AUDIO/VIDEO/PHOTOGRAPHS ***(If this is not applicable to your study and/or if participants do not have a choice of being audio/video-recorded or photographed, delete this section.)***

□ *I agree to be audio/video-recorded /photographed* ***(remove the media not being used)***

□ *I do not want to be audio/video-recorded /photographed* ***(remove the media not being used)***

_____
Name of Participant

_____
Signature of Participant Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

_____

Roxanne Smith- Name of Person Obtaining Consent

_____

Signature of Person Obtaining Consent Date

APPENDIX C

Recruitment Script

Dear Potential Participant,

My name is Roxanne Smith, and I am a doctoral student in the Graduate School of Education and Psychology at Pepperdine University. I am conducting a research study examining strategies of healthcare leaders in improving health outcomes and you are invited to participate in the study. If you would like to participate in a face-to-face interview, we can schedule the interview at a location of your choice or via video conferencing (i.e. Skype, Zoom). The interview is anticipated to take no more than one hour to complete. With your permission, I would also like to audio-record our conversation to review it as necessary to complete my research. Participation in this study is voluntary. Your identity as a participant will remain confidential during and after the study. To protect confidentiality, I will not publish the interview location or video conferencing address and will use a code instead of names on all securely stored notes and audio files associated with your interview. If you would be willing to be interviewed as part of this study, let me know what your availability might be during the month of _____. If at any time, you decide you do not wish to participate in the study, you can inform by e-mail.

Thank you for your participation,

Roxanne Smith
Pepperdine University
Graduate School of Education and Psychology
Status: Doctoral Student
roxanne.smith@pepperdine.edu

Dr. Farzin Madjidi
Dissertation Chair
Associate Dean, Graduate School of Education and Psychology
Pepperdine University
farzin.madjidi@pepperdine.edu

APPENDIX D

Peer Reviewer Form

Dear Reviewer:

Thank you for agreeing to participate in my research study. The table below is designed to ensure that my research questions for the study are properly addressed with corresponding interview questions

In the table below, please review each research question and the corresponding interview questions. For each interview question, consider how well the interview question addresses the research question. If the interview question is directly relevant to the research question, please mark "Keep as stated." If the interview question is irrelevant to the research question, please mark "Delete it." Finally, if the interview question can be modified to best fit with the research question, please suggest your modifications in the space provided. You may also recommend additional interview questions you deem necessary.

Once you have completed your analysis, please return the completed form to me via e-mail to roxanne.smith@pepperdine.edu. Thank you again for your participation.

Research Question	Corresponding Interview Question
RQ1: Placeholder	Placeholder a. The question is directly relevant to Research question - **Keep as stated** b. The question is irrelevant to research question – **Delete it** c. The question should be **modified as suggested**: _____ _____ I recommend adding the following interview questions: _____ _____
RQ2: Placeholder	Placeholder a. The question is directly relevant to Research question - **Keep as stated** b. The question is irrelevant to research question – **Delete it** c. The question should be **modified as suggested**: _____ _____ I recommend adding the following interview questions: _____ _____ _____
RQ3: Placeholder	Placeholder
RQ4: Placeholder	Placeholder