

Appendix G

Suggested Reading

1. **Article: *Leading Change: Why Transformation Efforts Fail.***

By: Kotter JP.

Published by: *Harvard Business Review*. 1995;73(2):59-67.

Abstract: In the past decade, the author has watched more than 100 companies try to remake themselves into better competitors. Their efforts have gone under many banners: total quality management, reengineering, right sizing, restructuring, cultural change, and turnarounds. In almost every case, the goal has been the same: to cope with a new, more challenging market by changing how business is conducted. A few of those efforts have been very successful. A few have been utter failures. Most fall somewhere in between, with a distinct tilt toward the lower end of the scale. The lessons that can be learned will be relevant to more and more organizations as the business environment becomes increasingly competitive in the coming decade. One lesson is that change involves numerous phases that, together, usually take a long time. Skipping steps creates only an illusion of speed and never produces a satisfying result. A second lesson is that critical mistakes in any of the phases can have a devastating impact, slowing momentum and negating previous gains. Kotter's lessons are instructive, for even the most capable managers often make at least one big error.

2. **Book: *The Heart of Change Field Guide: Tools and Tactics for Leading Change in Your Organization***

By: Dan S. Cohen

Published by: HBS Press

Description: In 1996, John P. Kotter's *Leading Change* became a runaway best seller, outlining an eight-step program for organizational change that was embraced by executives around the world. Then, Kotter and co-author Dan Cohen's *The Heart of Change* introduced the revolutionary "see-feel-change" approach, which helped executives understand the crucial role of emotion in successful change efforts. Now, *The Heart of Change Field Guide* provides leaders and managers tools, frameworks, and advice for bringing these breakthrough change methods to life within their own organizations. Written by Dan Cohen and with a foreword by John P. Kotter, the guide provides a practical framework for implementing each step in the change process, as well as a new three-phase approach to execution: creating a climate for change, engaging and enabling the whole organization, and implementing and sustaining change. Hands-on diagnostics – including a crucial "change readiness module" – reveal the dynamics that will help or hinder success at each phase of the change process. Both flexible and scaleable, the frameworks presented in this guide can be tailored for any size or type of change initiative. Filled with practical tools, checklists, and expert commentary, this must-have guide translates the most powerful approaches available for creating successful change into concrete, actionable steps for you and your organization. Dan Cohen is the co-author, with John P. Kotter, of *The Heart of Change*, and a principal with Deloitte Consulting, LLC.

3. **Article: *The Effect of Race on the Referral Process for Invasive Cardiac Procedures.***

By: Einbinder LC, Schulman KA.

Published by: *Medical Care Research and Review*. 2000;57 Suppl 1:162-180.

Abstract: Coronary artery disease is the leading cause of death in the United States. Blacks are more likely than whites to experience premature disease, and they have poorer prognosis after acute myocardial infarction. Multiple studies have demonstrated that blacks are less likely to be referred for certain invasive cardiac procedures. Few studies have examined the effect of race on physician and patient decision making in referrals for cardiac procedures. The authors present a framework for the complex series of steps involved in obtaining invasive cardiac care. Patient race can affect each of these steps, and differences in physician and patient race may be a particular impediment to effective communication about symptoms and preferences and to the establishment of a therapeutic partnership. The potential role of communication in race-discordant physician-patient relationships suggests a need for more research in physician decision making and for efforts to promote cultural competency as a core component of medical education.

4. **Article: *Inequality in quality: addressing socioeconomic, racial, and ethnic disparities in health care.***

By: Fiscella K, Franks P, Gold M, Clancy C.
Published by: *JAMA*. 2000;283(19):2579-2584.

Abstract: Socioeconomic and racial/ethnic disparities in health care quality have been extensively documented. Recently, the elimination of disparities in health care has become the focus of a national initiative. Yet, there is little effort to monitor and address disparities in health care through organizational quality improvement. After reviewing literature on disparities in health care, we discuss the limitations in existing quality assessment for identifying and addressing these disparities. We propose 5 principles to address these disparities through modifications in quality performance measures: disparities represent a significant quality problem; current data collection efforts are inadequate to identify and address disparities; clinical performance measures should be stratified by race/ethnicity and socioeconomic position for public reporting; population-wide monitoring should incorporate adjustment for race/ethnicity and socioeconomic position; and strategies to adjust payment for race/ethnicity and socioeconomic position should be considered to reflect the known effects of both on morbidity.

5. **Article: *Health care organizations' use of race/ethnicity data to address quality disparities.***

By: Nerenz D.
Published by: *Health Affairs*. 2005;24(2):409-416.

Abstract: Health care organizations—health plans, hospitals, community health centers, clinics, and group practices—can play an important role in the elimination of racial/ethnic disparities in health care. There are now a number of examples of organizations that have been successful in reducing or eliminating disparities, and a number of published examples of how quality improvement initiatives can improve care for members of targeted minority groups, thereby contributing to the elimination of disparities.

6. **Article: *Improving Quality and Achieving Equity: The role of cultural competence and quality in reducing racial/ethnic disparities in health care.***

By: Betancourt JR.
Published by: The Commonwealth Fund; 2006.

Abstract: This report reviews key principles of quality (as it relates to the overall quality of the health care system and individual approaches to quality improvement); reviews evidence of the existence and root causes of racial and ethnic health disparities and recommendations to address them; and discusses strategies by which the quality and cultural competence movements could be linked. In particular, it focuses on the Institute of Medicine's six principles for designing a high-quality health care system to identify areas where aspects of cultural competence would be central to achieving high quality. It then presents a framework outlining both hypothetical and proven strategies for delivering high-quality, culturally competent care.

7. **Article: *Eliminating Racial and Ethnic Disparities in Health Care: What Is the Role of Academic Medicine?***

By: Betancourt JR.
Published by: *Academic Medicine*. 2006;81(9):788-792.

Abstract: Research has shown that minority Americans have poorer health outcomes (compared to whites) from preventable and treatable conditions such as cardiovascular disease, diabetes, asthma, and cancer. In addition to racial and ethnic disparities in health, there is also evidence of racial and ethnic disparities in health care. The Institute of Medicine Report *Unequal Treatment* remains the preeminent study of the issue of racial and ethnic disparities in health care in the United States. *Unequal Treatment* provided a series of general and specific recommendations to address such disparities in health care, focusing on a broad set of stakeholders including academic medicine. Academic medicine has several important roles in society, including providing primary and specialty medical services, caring for the poor and uninsured, engaging in research, and educating health professionals. Academic medicine should also provide national leadership by identifying innovations and creating solutions to the challenges our health care system faces in its attempt to deliver high-quality care to all patients. Several of the recommendations of *Unequal*

Treatment speak directly to the mission and roles of academic medicine. For instance, patient care can be improved by collecting and reporting data on patients' race/ethnicity; education can minimize disparities by integrating cross-cultural education into health professions training; and research can help improve health outcomes by better identifying sources of disparities and promising interventions. These recommendations have clear and direct implications for academic medicine. Academic medicine must make the elimination of health care disparities a critical part of its mission, and provide national leadership by identifying quality improvement innovations and creating disparities solutions.

8. **Article: Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?**

By: Casalino LP, Elster A, Eisenberg A, Lewis E, Montgomery J, Ramos D.

Published by: *Health Affairs*. 2007;26(3):w405-414.

Abstract: Pay-for-performance (P4P) and public quality-reporting programs can increase the quality of health care for the services being measured. However, unless carefully designed, these programs may have the unintended consequence of increasing racial and ethnic disparities. This paper describes ways in which P4P and public reporting programs may increase disparities and suggests ways in which programs might be designed that will make them likely to reduce, or at least not increase, disparities.

9. **Article: Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients.**

By: Green AR, Carney DR, Pallin DJ, Ngo LH, Raymond KL, Iezzoni LI, Banaji MR.

Published by: *J Gen Intern Med*. 2007 Sep;22(9):1231-8.

Abstract: CONTEXT: Studies documenting racial/ethnic disparities in health care frequently implicate physicians' unconscious biases. No study to date has measured physicians' unconscious racial bias to test whether this predicts physicians' clinical decisions. OBJECTIVE: To test whether physicians show implicit race bias and whether the magnitude of such bias predicts thrombolysis recommendations for black and white patients with acute coronary syndromes. DESIGN, SETTING, AND PARTICIPANTS: An internet-based tool comprising a clinical vignette of a patient presenting to the emergency department with an acute coronary syndrome, followed by a questionnaire and three Implicit Association Tests (IATs). Study invitations were e-mailed to all internal medicine and emergency medicine residents at four academic medical centers in Atlanta and Boston; 287 completed the study, met inclusion criteria, and were randomized to either a black or white vignette patient. MAIN OUTCOME MEASURES: IAT scores (normal continuous variable) measuring physicians' implicit race preference and perceptions of cooperativeness. Physicians' attribution of symptoms to coronary artery disease for vignette patients with randomly assigned race, and their decisions about thrombolysis. Assessment of physicians' explicit racial biases by questionnaire. RESULTS: Physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness. In contrast, IATs revealed implicit preference favoring white Americans (mean IAT score = 0.36, $P < .001$, one-sample t test) and implicit stereotypes of black Americans as less cooperative with medical procedures (mean IAT score 0.22, $P < .001$), and less cooperative generally (mean IAT score 0.30, $P < .001$). As physicians' prowhite implicit bias increased, so did their likelihood of treating white patients and not treating black patients with thrombolysis ($P = .009$). CONCLUSIONS: This study represents the first evidence of unconscious (implicit) race bias among physicians, its dissociation from conscious (explicit) bias, and its predictive validity. Results suggest that physicians' unconscious biases may contribute to racial/ethnic disparities in use of medical procedures such as thrombolysis for myocardial infarction.

10. **Article: A Plan for Action: Key Perspectives from the Racial/Ethnic Disparities Strategy Forum**

By: King RK, Green AR, Tan-McGrory A, Donahue EJ, Kimbrough-Sugick JK, Betancourt, JR.

Published by: *Milbank Q*. Jun 2008;86(2):241-272.

Abstract: Racial and ethnic disparities in health care in the United States have been well documented, with research largely focusing on describing the problem rather than identifying the best practices or proven strategies to address them. In 2006, the Disparities Solutions Center convened a one-and-a-half-day Strategy Forum composed of twenty experts from the fields of racial/ethnic disparities in health care, quality improvement, implementation research, and organizational excellence, with the goal of deciding on innovative action items and adoption strategies

to address disparities. The forum used the Results Based Facilitation model, and several key recommendations emerged. The forum's participants concluded that to identify and effectively address racial/ethnic disparities in health care, health care organizations should: (1) collect race and ethnicity data on patients or enrollees in a routine and standardized fashion; (2) implement tools to measure and monitor for disparities in care; (3) develop quality improvement strategies to address disparities; (4) secure the support of leadership; (5) use incentives to address disparities; and (6) create a messaging and communication strategy for these efforts. This article also discusses these recommendations in the context of both current efforts to address racial and ethnic disparities in health care and barriers to progress. The Strategy Forum's participants concluded that health care organizations needed a multifaceted plan of action to address racial and ethnic disparities in health care. Although the ideas offered are not necessarily new, the discussion of their practical development and implementation should make them more useful.

11. **Article: Language proficiency and adverse events in US hospitals: a pilot study.**

By: Divi C, Koss RG, Schmaltz SP, Loeb JM.

Published by: *Int J Qual Health Care*. 2007 Apr;19(2):60-7.

Abstract: OBJECTIVE: To examine differences in the characteristics of adverse events between English speaking patients and patients with limited English proficiency in US hospitals. SETTING: Six Joint Commission accredited hospitals in the USA. METHOD: Adverse event data on English speaking patients and patients with limited English proficiency were collected from six hospitals over 7 months in 2005 and classified using the National Quality Forum endorsed Patient Safety Event Taxonomy. RESULTS: About 49.1% of limited English proficient patient adverse events involved some physical harm whereas only 29.5% of adverse events for patients who speak English resulted in physical harm. Of those adverse events resulting in physical harm, 46.8% of the limited English proficient patient adverse events had a level of harm ranging from moderate temporary harm to death, compared with 24.4% of English speaking patient adverse events. The adverse events that occurred to limited English proficient patients were also more likely to be the result of communication errors (52.4%) than adverse events for English speaking patients (35.9%). CONCLUSIONS: Language barriers appear to increase the risks to patient safety. It is important for patients with language barriers to have ready access to competent language services. Providers need to collect reliable language data at the patient point of entry and document the language services provided during the patient-provider encounter.

12. **Article: The effect of English language proficiency on length of stay and in-hospital mortality.**

By: John-Baptiste A, Naglie G, Tomlinson G, Alibhai SM, Etchells E, Cheung A, Kapral M, Gold WL, Abrams H, Bacchus M, Krahn M.

Published by: *J Gen Intern Med*. 2004 Mar;19(3):221-8.

Abstract: BACKGROUND: In ambulatory care settings, patients with limited English proficiency receive lower quality of care. Limited information is available describing outcomes for inpatients. OBJECTIVE: To investigate the effect of English proficiency on length of stay (LOS) and in-hospital mortality. DESIGN: Retrospective analysis of administrative data at 3 tertiary care teaching hospitals (University Health Network) in Toronto, Canada. PARTICIPANTS: Consecutive inpatient admissions from April 1993 to December 1999 were analyzed for LOS differences first by looking at 23 medical and surgical conditions (59,547 records) and then by a meta-analysis of 220 case mix groups (189,119 records). We performed a similar analysis for in-hospital mortality. MEASUREMENTS: LOS and odds of in-hospital death for limited English-proficient (LEP) patients relative to English-proficient (EP) patients. RESULTS: LEP patients stayed in hospital longer for 7 of 23 conditions (unstable coronary syndromes and chest pain, coronary artery bypass grafting, stroke, craniotomy procedures, diabetes mellitus, major intestinal and rectal procedures, and elective hip replacement), with LOS differences ranging from approximately 0.7 to 4.3 days. A meta-analysis using all admission data demonstrated that LEP patients stayed 6% (approximately 0.5 days) longer overall than EP patients (95% confidence interval, 0.04 to 0.07). LEP patients were not at increased risk of in-hospital death (relative odds, 1.0; 95% confidence interval, 0.9 to 1.1). CONCLUSIONS: Patients with limited English proficiency have longer hospital stays for some medical and surgical conditions. Limited English proficiency does not affect in-hospital mortality. The effect of communication barriers on outcomes of care in the inpatient setting requires further exploration, particularly for selected conditions in which length of stay is significantly prolonged.

13. **Article: *Language barriers and resource utilization in a pediatric emergency department.***

By: Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE.
Published by: *Pediatrics*. 1999 Jun;103(6 Pt 1):1253-6.

Abstract: BACKGROUND: Although an inability to speak English is recognized as an obstacle to health care in the United States, it is unclear how clinicians alter their diagnostic approach when confronted with a language barrier (LB). OBJECTIVE: To determine if a LB between families and their emergency department (ED) physician was associated with a difference in diagnostic testing and length of stay in the ED. DESIGN: Prospective cohort study. METHODS: This study prospectively assessed clinical status and care provided to patients who presented to a pediatric ED from September 1997 through December 1997. Patients included were 2 months to 10 years of age, not chronically ill, and had a presenting temperature ≥ 38.5 degrees C or complained of vomiting, diarrhea, or decreased oral intake. Examining physicians determined study eligibility and recorded the Yale Observation Score if the patient was < 3 years old, and whether there was a LB between the physician and the family. Standard hospital charges were applied for each visit to any of the 22 commonly ordered tests. Comparisons of total charges were made among groups using Mann-Whitney U tests. Analysis of covariance was used to evaluate predictors of total charges and length of ED stay. RESULTS: Data were obtained about 2467 patients. A total of 286 families (12%) did not speak English, resulting in a LB for the physician in 209 cases (8.5%). LB patients were much more likely to be Hispanic (88% vs 49%), and less likely to be commercially insured (19% vs 30%). These patients were slightly younger (mean 31 months vs 36 months), but had similar acuity, triage vital signs, and Yale Observation Score (when applicable). In cases in which a LB existed, mean test charges were significantly higher: \$145 versus \$104, and ED stays were significantly longer: 165 minutes versus 137 minutes. In an analysis of covariance model including race/ethnicity, insurance status, physician training level, attending physician, urgent care setting, triage category, age, and vital signs, the presence of a LB accounted for a \$38 increase in charges for testing and a 20 minute longer ED stay. CONCLUSION: Despite controlling for multiple factors, the presence of a physician-family LB was associated with a higher rate of resource utilization for diagnostic studies and increased ED visit times. Additional study is recommended to explore the reasons for these differences and ways to provide care more efficiently to non-English-speaking patients.

14. **Book: *The Heart of Change: Real-Life Stories of How People Change Their Organizations***

By: John P. Kotter, Dan S. Cohen
Published by: HBS Press

Description: For individuals in every walk of life and in every stage of change, this compact, no-nonsense book captures both the heart – and the “how” – of successful change. Organizations are forced to change faster and more radically than ever. How are companies faring in meeting these challenges – and what can we learn from their experiences? In this powerful follow-up book – organized around Leading Change’s revolutionary eight-step change process – Kotter and co-author Dan Cohen reveal the results of their research in over 100 organizations in the midst of large-scale change. What they found may surprise you. Although most organizations believe change happens by making people think differently – Kotter and Cohen say the key lies more in making them feel differently. They introduce a new dynamic – “see-feel-change” – that sparks and fuels action by showing people potent reasons for change that charge their emotions. Through true stories from real people, the authors present a play-by-play of challenges encountered, mistakes made, and lessons learned through each of the eight steps of change – and offer tips and tools readers can apply within their own organizations.