Sentinel Event Alert

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Addressing health care disparities by improving quality and safety

The Joint Commission considers addressing health care disparities a quality and patient safety imperative, as well as a moral and ethical duty. Our enterprise's mission to continuously improve health care commits us to finding solutions to these inequities.

"Disparities in health care is one of the most studied and researched problems; there are overwhelming evidence and persistence of gaps in virtually all areas of health care," said Dr. Ana McKee, executive vice president, chief medical officer and chief diversity and inclusion officer, The Joint Commission. "This is a problem that is a major patient safety issue; it provides and introduces as much risk of harm as a central line infection or a fall. We encourage all organizations to address disparities as a patient safety concern."[1]

This *Sentinel Event Alert* summarizes strategies for health care and human services organizations in all settings as they begin to address health care disparities; it also provides examples of successful initiatives for organizations that are well on their way. This alert can guide organizations as they address disparities as a central part of performance and patient safety improvement and hardwire the pursuit of health equity into their strategic planning.

The Henry J. Kaiser Family Foundation defines health care disparities as "differences between groups in health coverage, access to care, and quality of care."[2] While these disparities are commonly viewed through the lens of race and ethnicity, they occur across many dimensions, including socioeconomic status, age, location, gender, disability status, and sexual orientation and expression.

According to the Centers for Disease Control and Prevention, non-Hispanic Black women are three times more likely to die from a pregnancy-related cause than white women.[3] The COVID-19 pandemic has widened disparity gaps. Non-Hispanic Blacks and Hispanics with COVID-19 experienced nearly three times the rate of hospitalization as whites,[4] and both demographic groups combined experienced more than half of COVID-19 deaths nationally while representing only a third of the population, according to age-standardized data.[5] Sexual minority persons in the U.S. also reported a higher prevalence of severe outcomes from COVID-19 than heterosexual persons, both within the overall population and among racial/ethnic minority groups.[6]

In addition, racial and ethnic minorities are less likely to receive treatment for depression, substance abuse, and other behavioral health conditions.[7] Patients and clients with limited English proficiency face barriers to health care access, experience lower quality care, and suffer worse outcomes.[8] Disparities relating to gender,[9] culture,[10] religion,[11] disabilities and more abound.

Developing your quality and safety improvement program to address disparities

A practical way to start addressing health care disparities in your organization is to engage your current quality and safety improvement program to identify opportunities for improvement in the communities your organization serves. This requires developing community partnerships to help you to fully understand the root causes that impede access and cause distrust and to uncover other barriers that may exist. Embedding these improvement efforts into your organization's

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quality improvement infrastructure allows you to monitor metrics and progress toward health equity goals along with all other improvement activities.

Addressing disparities on Chicago's West Side

Driven by large life-expectancy gaps in its primary service area compared to other Chicago neighborhoods, Rush University Medical Center in Chicago developed a five-pronged framework to support a health equity strategy focused on applying quality and safety principles to reduce and ultimately eliminate disparities affecting excluded or marginalized groups. The framework includes a commitment to offer employment opportunities to individuals living on Chicago's West Side and to create wealth-building opportunities for employees. This strategy binds governance, leaders and the workforce together in a concerted effort to eliminate racism and health care inequities and to address social and structural determinants of health.[12]

Actions suggested by The Joint Commission

"A robust culture of equity depends on staff and providers recognizing that disparities may exist within a patient population and taking responsibility for reducing them." – "A Roadmap to Reduce Racial and Ethnic Disparities in Health Care," Robert Woods Johnson Foundation[13]

The following actions have been adopted by health care organizations across the nation, as they begin to take responsibility for ensuring that the same quality of care is provided to patients in all settings.

1. Collect and stratify quality and safety performance data specific to the communities your organization serves, and develop communication channels that enable you to listen and learn.

Health care leaders should not assume they understand the drivers of disparities in the communities they serve, including disparities within their workforce. "Communities served by your health care organization may be experiencing health care disparities, but you may not know that," said Dr. McKee. "Gathering data and creating opportunities for communities to give voice to their experiences are among the ways to start the listening and learning process that's so essential to addressing disparities."

Understanding your organization's current quality and safety performance according to the various demographic groups you serve is essential to addressing health care disparities. For this reason, collecting quality and safety data and then stratifying the data according to your organization's patient and workforce demographics are important first steps. Health care organizations commonly stratify these data according to demographics such as race, ethnicity, and language (REaL); sexual orientation/gender identity (SO/GI); disability; social determinants of health; geography; health insurance coverage; access to providers and pharmacies; and other factors that may contribute to health care disparities.[14]

Integrating these data into standard workflows and tools, including within the electronic medical record and quality and safety dashboard, will facilitate goal setting, as well as ongoing measurement and progress.[14] Supplementing these data by listening to and giving voice to marginalized communities via personal interviews with patients, workers, advisory councils, or focus groups adds human experience to the numbers. These qualitative methods may also serve as a proxy if your organization lacks stratified data that points out specific disparities in your patient population.[13]

Improving the quality of care of transgender and gender nonconforming patients

Many transgender and gender nonconforming (TGNC) patients choose to delay or not seek health care when necessary because they fear discrimination or mistreatment. In response, the Vanderbilt Program for LGBTQ Health engaged the community of TGNC patients in the creation of a transgender patient advocacy program, a community advisory board, and a transgender health clinic. To support the continuous quality improvement of transgender health care and to make the health care environment more welcoming and inclusive to TGNC patients, the program piloted a monitoring and evaluation system to identify the clinics and health services most used by TGNC patients and assess the level of patient satisfaction in each area. This process supports the identification of high- and low-performing clinics and health services and allows for the development of training programs to improve the quality of culturally competent health care TGNC patients receive systemwide.[15]

Developing two-way channels of communication with stakeholders, especially communities experiencing health disparities, and forging working relationships with community leaders lead to informed decision-making of benefit to all parties. These conversations and collaborations will help your organization to build empowering alliances with voices and communities that were previously excluded.[16]

2. Analyze stratified data and community feedback to identify health care disparities and opportunities for improvement.

Overcoming health disparities will require understanding social determinants of health that affect the communities your organization serves. It's important to focus on determinants that your organization can affect through actions such as creating better access to care, referring patients or clients to behavioral health or social services, developing "plain language" health education materials, and providing interpreter services. Other determinants – such as food insecurity, housing instability and utility stress – are generally caused by unemployment and poverty, inadequate family/social supports and structures, and other factors; these determinants impact health care outcomes directly but may be challenging for health care organizations to address alone.

The analysis of national data shows health care disparities affecting health outcomes relating to COVID-19, maternal care, influenza and COVID-19 vaccination, cancer screenings, pain management, behavioral health, and chronic medical conditions such as diabetes and hypertension. However, health care disparities depicted by national or regional data may be different than those affecting the population you serve. Having your own data helps your organization to identify disparities that may exist both within your walls and in your community.

Taking the time and effort to understand why disparities exist requires carefully examining potential root causes. Forming a diverse team, including clinicians, patients, and community members, to analyze and investigate your quantitative and qualitative findings will help you to arrive at telling insights.

For example, let's say data show that Black patients with diabetes receive less frequent foot exams than white patients, leading to a higher occurrence of diabetic complications such as neuropathies and complications secondary to vascular disease. Further investigation determines that under-reporting of foot exams and fewer referrals for foot exams given to Black patients are not contributing factors. However, the team finds that Black patients are less likely to use the referrals because parking at the podiatrists' offices is expensive and there is no access to public transportation. To rectify this problem, the clinic establishes relationships with more conveniently located clinics that are also served by public transportation, encourages patients to ask for referrals to these clinics, and makes new referrals for patients without foot exams.[13]

Over time, improvements in the rate of foot examinations and completed follow-up visits to the podiatrist begin to reduce diabetes-related complications. The disparity in this example begins to shrink due to following a careful step-by-step process to analyze the data, determine root causes, and develop interventions to address them.[13]

Using robust data to find and address disparities relating to COVID-19

Brigham Health, a member of the Mass General Brigham Health System, developed data infrastructure to understand the impact of COVID-19 on its patients and staff. The organization visualized data through dashboards that informed hospital operations and developed strategies to reduce harm associated with racism and other forms of structural discrimination. Brigham Health used data filters to examine the intersectional effect of COVID-19 on groups with multiple identities – for example, women who are also Black – to identify hot-spot neighborhoods where ramped-up testing and masks were required; and to ensure that disadvantaged groups were included in a study evaluating the potential benefit of Remdesivir. Stratified data also discovered that frontline employee groups – including environmental and food services, materials management, and patient care assistants – were tested less often and tested positive at up to 10 times the rate of higher socioeconomic employee groups such as physicians and nurses.[17]

3. Commit to achieving diversity and inclusion as an important step toward addressing health care disparities.

Understanding the disparities affecting the population you serve and the challenges your

patients or clients face should drive your organization's diversity and inclusion initiative. The challenge here is to develop a governance structure, leadership team and workforce that reflect the diversity of the community you serve.[14] Making this kind of commitment to diversity and inclusion builds trust in an organization and enables it to extend the trust into the community. Building this trust is necessary to overcome systemic inequities present in virtually all organizations and communities.[12,18]

An important aspect of a diversity and inclusion initiative is an effort to achieve cultural competency – the ability to provide care to patients having diverse values, beliefs and behaviors and to render this care free of implicit, or unconscious, bias. Culturally competent organizations are able to tailor health care delivery to meet patients' social, cultural and linguistic needs.[14]

As a strategy toward reducing health care disparities, health care organizations can intentionally recruit clinicians who reflect the diversity of the populations they serve. In addition, cultural competency training for all staff has become commonplace within health care organizations. Shaping the clinical workforce in these ways intertwines diversity, inclusion and cultural competency in the effort to address disparities.[14]

"The best way for an organization to achieve cultural competency is to have staff members who reflect the diversity of the patients it serves and who understand patients' history, concerns, fears, and cultural beliefs," said Dr. David Baker, executive vice president for Health Care Quality Evaluation at The Joint Commission. A lack of cultural understanding may result in harm to a patient, he said. "For example, Muslims typically fast during Ramadan. During this holiday, Muslim patients with diabetes could be at risk of low blood sugar if their health care providers are unaware of the tradition of fasting and do not talk with patients about how best to deal with diabetes medications."

According to the Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," there is a strong correlation between clinicians who reflect the communities they serve and their ability to build the trust necessary to achieve treatment adherence and other positive health behaviors from their patients.[19]

4. Undertake initiatives to rectify health care disparities by building sustainable business cases.

Health disparities cause about $93 billion in excess medical care costs and $42 billion in lost productivity each year, according to a national analysis.[20] Wyatt, et al., 2016, projected the economic burden of health disparities in the U.S. to be $126 billion in 2020 and $353 billion in 2050 if the disparities remain unchanged.[21] Addressing disparities can have financial benefits for health care organizations.

An important way to address disparities is to screen for, identify, and treat conditions such as cancer, diabetes, hypertension, chronic kidney disease, and substance abuse in the early stages, when treatment is more timely and effective for patients or clients and more profitable for health care organizations. Treating patients or clients in this way is rewarded by value-based care models such as risk contracting, accountable care organizations, and bundled payments. Providing screenings and early-stage treatments to populations experiencing disparities also helps your organization avoid having to provide high-cost treatments such as crash dialysis, therapies for advanced cancers that were diagnosed in later stages, and heart procedures made necessary by untreated or undertreated hypertension.

Your chief medical officer or chief nursing officer and clinician colleagues can work together with your chief executive and financial officer to build business cases that measure the impact that addressing disparities will have on your organization's costs, productivity, employee satisfaction, and brand value.[22-24] Your business case will inform the time, talent and financial resources required to begin disparities reduction. A series of articles from Optum outlines specific steps CEOs,[22] CFOs[23] and CMOs[24] can take to address health care disparities. Many organizations have or have begun to search for leaders to fill diversity, equity and inclusion roles, and these officers can lead and participate in these collaborative efforts.

"Leadership's role is to become a champion," Dr. McKee stated. "It's to provide appropriate resourcing and staffing to set the strategies, to

set culture, and to do that with a data- and metric-driven mindset." She also recommends focusing your initiative on a few key actionable measures aligned with organizational priorities to keep efforts manageable and not overwhelming to staff.

When building a business case, your organization can determine feasibility and importance by considering factors such as:

- Existing resources and infrastructure—How much of what we will need is already in place?
- Reach—What portion of the priority population is affected?
- Urgency—Is immediate action necessary?
- Cost—How much funding is needed to address root causes and reduce disparities? Is a financial gain possible?
- Effort—Are there enough labor and time to address the issue?
- Sustainability—Can the initiative sustain itself financially through cost reduction or increased revenues?[13]

Further strengthening the importance of reducing health care disparities to improve financial performance, the Centers for Medicare and Medicaid Services has communicated its intentions to rely much more on value-based direct contracting models, which it calls "the next evolution of risk-sharing arrangements." This approach promises to improve quality of care for beneficiaries while reducing costs. Under this approach, health care providers coordinate the care of beneficiaries as Direct Contracting Entities (DCEs), taking full financial risk along with shared savings or losses.[25] During the pandemic, value-based contracts enabled organizations to maintain revenue when volumes and fee-for-service payments dropped.[26]

As stated in its statement on racial justice and equity, "The Joint Commission is committed to safe, high-quality health care for *all*. We require our accredited organizations to protect the rights of individuals and prohibit discrimination. Our patient-centered communication standards guide providers to assure that people of all races, backgrounds, disabilities and income levels receive care that is free of prejudice. But none of us acting alone can solve this problem. This is a challenge that dates to our country's founding. The only way to overcome it will be to work together."

Reducing racial disparities in severe maternal morbidity from hemorrhage

A quality improvement collaborative in California reduced racial disparities in severe maternal morbidity from hemorrhage by implementing national safety bundles consisting of 17 evidence-based recommendations known to improve outcomes. The collaborative reduced morbidity rates in all races while decreasing disparities between Black and white women.[27]

Related Joint Commission requirements

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These publications were drawn upon to develop this alert and serve as excellent resources to gain further information about leading practices in addressing disparities.

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Other resource:
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Patient Safety Advisory Group
The Patient Safety Advisory Group informs The Joint Commission on patient safety issues and, with other sources, advises on topics and content for *Sentinel Event Alert*.

Joint Commission Requirements Addressing Health Equity Issues

The following table presents the health equity issues (e.g., race, ethnicity, language, culture, religion, spirituality) addressed in Joint Commission accreditation requirements across programs.

Requirement	Program
Collect Race and Ethnicity Data	Ambulatory (Primary Care Medical Home) Behavioral Health (Behavioral Health Home) Critical Access Hospital (Primary Care Medical Home) Hospital (RC.02.01.01, EP 25)
Collect Language Data, including: • Language and Communication Needs • Preferred Language Data	Ambulatory Behavioral Health Critical Access Hospital Home Care Hospital (RC.02.01.01, EP 1) Nursing Care Center
Address Language Needs: • Respect the Need for Effective Communication • Identify and Address Communication Needs • Meet Communication Needs • Provide Interpreter and Translation Services • Address Vision, Speech, Hearing Needs	Ambulatory Behavioral Health Critical Access Hospital Home Care Hospital (PC.02.01.21, EPs 1-2; PC.02.03.01, EP 1; RI.01.01.01, EP 5; RI.01.01.03, EPs 1-3) Nursing Care Center
Address Health Literacy Needs	Ambulatory (Primary Care Medical Home) Behavioral Health (Behavioral Health Home) Critical Access Hospital (Primary Care Medical Home) Hospital (Primary Care Medical Home) (PC.02.03.01, EPs 30-31)
Address Cultural Needs	Ambulatory Behavioral Health Critical Access Hospital Home Care Hospital (PC.02.03.01, EP 1; RI.01.01.01, EPs 6) Nursing Care Center
Address Religious and Spiritual Needs	Behavioral Health Critical Access Hospital Home Care Hospital (PC.02.03.01, EP 1; RI.01.01.01, EPs 9) Nursing Care Center
Qualifications for Language Interpreters and Translators	Hospital (HR.01.01.01, EP 1, Note 4)
Access to Support Individual	Critical Access Hospital Hospital (RI.01.01.01, EPs 2, 28)
Prohibit Discrimination	Critical Access Hospital Hospital (RI.01.01.01, EP 29)